

CFP WRAPAROUND REFERRAL FORM

Eligibility Criteria for Wraparound

A child/youth ages 0-21 with a Mental Health diagnosis, who has experienced moderate/severe functional impairments measured by the CAFAS/PECFAS/DECA-C for a period of 6 months **and two** or more of the following criteria:

- involved in multiple child/youth serving systems
- at risk for out-of-home placements or currently in out-of-home placement
- has been served through other mental health services with minimal improvement in functioning
- risk factors exceed capacity for traditional community-based options
- numerous providers are serving multiple children/youth in the family and the identified outcomes are not being met

* Consult with your supervisor, mental health liaison and/or DeWanna Lancaster, CFP Service Coordinator, with questions around potential referrals.

Indicate the CFP Service(s) you are requesting on behalf of the child/youth/family:

- Wraparound SED Waiver (ages 0-21 has an SED as demonstrated by CAFAS score: with severity existing over 6 months)
Medicaid status is active and was verified prior to referral: yes - CONTINUE no – CONTACT DEWANNA LANCASTER

Section I: To be completed by referring party

1. **Child/youth name:** _____

Last
First
MI
 2. **Child/youth Date of Birth:** _____ **Age:** _____
 3. **What sex was the youth assigned at birth, on the original birth certificate?** Male Female
 4. **Current Gender Identity: how does the youth describe themselves? (check one)**
 Male Female Transgender Do not identify as female, male, or transgender
 5. **Sexual Orientation:** Heterosexual/straight Gay Lesbian Bisexual Unknown/Other
 6. **Child/youth Network180 Number:** _____
 7. **Is the child of Hispanic or Latin cultural/ethnic background?** Yes No
If YES: Which group describes his/her Hispanic or Latin cultural/ethnic background? (select all that apply)
 Mexican, Mexican-American, or Chicano Central American Puerto Rican
 South American Cuban Dominican
 Other Hispanic origin - specify _____
 8. **Which best describes the child? Is he/she... (select all that apply)**
 American Indian Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White or Euro-American
 Other please specify: _____
 9. **What school does the child attend?** _____
Special Education: LD EI CI Other (specify) _____ Speech/Hearing Impaired N/A
 10. **What is the highest level of education the child has completed, whether or not they received a degree?**
 Pre-K 1st 3rd 5th 7th 9th 11th Vocational/Technical Diploma Don't know
 Kindergarten 2nd 4th 6th 8th 10th 12th /GED Some college/university Never attended
 11. **Placement at time of referral (check all that apply):**
 Home Residential Psychiatric Hospital Detention Other: _____
 Foster Care (Specify Relative Placement Non-relative Placement)
 Guardian Placement (Specify Relative Placement Non-relative Placement)
- Address of child's residence at time of referral: _____ Zip code: _____
- Phone number of child's residence at time of referral: (_____) _____

12. Name of legal guardian or responsible party: _____

Address: _____

Relationship to Child: _____ Phone: _____

Legal Guardian's email address: _____

13. If the child is in Foster Care, name of foster parent(s): _____

14. Indicate the systems that the child is presently receiving services or supports:

Juvenile Justice (Adjudicated Non-adjudicated) Service: _____
Probation Officer: _____ Phone: _____

DHHS (Public Child Welfare):
 Current/open Child Abuse and Neglect Investigation Category: I II III IV V
 Out-of-home Placement Kinship Care Residential Treatment
 In-home Services (specify) _____

Please indicate: Voluntary Placement/service Court-ordered Placement/service Prevention
DHHS Worker: _____ Phone: _____

Foster Care Agency: _____
Worker: _____ Phone: _____

Mental Health Service (home based, outpatient, etc.): _____
Therapist & Agency: _____ Phone: _____
Psychiatrist & Agency: _____ Phone: _____

Education (Special Education 504 Behavioral Plan) Other: _____
School Contact & Role: _____ Phone: _____

Medical: Child is healthy: Yes No (Circle one) Child has an ongoing medical condition requiring coordination (diabetes, cancer, severe asthma, etc.)
Describe Condition: _____
Coordinating Physician/Specialist: _____ Phone: _____

Other Community Supports
Type: _____ Phone: _____
Type: _____ Phone: _____

15. Primary language spoken in client's home: _____ interpreter needed? Yes No

16. Out of Home Placement History (please include all previous out of home placements including detention and emergency shelter. A placement record with details may be attached to CFP referral).

Number of placements has the youth had: Foster Care _____ Residential _____ Psychiatric Hospitalizations _____

Name/Type of Placement	Dates of Placement (duration)	Reason for Placement/Comments

17. Is the child at risk of placement out of the home or placement in a more restrictive setting?

Yes No If yes specify risk:

18. List presenting crises and safety issues:

19. Additional reasons for referral: Please provide specific behaviors/emotional concerns:

Name of person initiating CFP referral: _____ Organization: _____

Source of referral: Juvenile Justice DHS MH Provider Foster Care KSSN Education Net180 Other: _____

Phone number _____ E-mail _____

Relationship to child/youth: _____ Date Referral submitted: _____

If different, name of person completing this form: _____ Organization: _____

STOP: Probation Officers send to Court Liaison with most recent report. CPS / Foster Care Worker send to DHHS Liaison with most recent USP. Mental Health Therapists continue.

Section II: to be completed by clinician in partnership with family during family meeting.

20. During the past 6 months was the client the recipient of: (check all that apply)

- Medicaid
- Supplemental Security Income- SSI
- Temporary Assistance to Needy Families-TANF
- Food Stamps
- Women, Infant, and Children- WIC
- Children’s Health Insurance Plan-CHIP
- MI Child
- Private Insurance

21. What kind of health insurance does the client currently have? (check all that apply)

- Medicaid
- Insurance through caregiver’s employer
- Eligible for adoption subsidy
- CHIP (Children’s Health Insurance Program)
- Insurance through the exchange or marketplace, such as Healthcare.gov
- No health insurance
- Supplemental Security Income (SSI)
- Insurance through the military
- Don’t know
- Healthy Michigan Plan
- Insurance through the Indian Health Service
- Other type of health insurance: _____

22. Indicate prior services/supports that the child/family has utilized in the past:

<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Youth Enhancement	<input type="checkbox"/> Parenting classes
<input type="checkbox"/> Case Management (mental health)	<input type="checkbox"/> Dialectal Behavior Therapy	<input type="checkbox"/> CHILL
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> PMTO	<input type="checkbox"/> ABC
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Trauma Focused CBT	<input type="checkbox"/> Minors in Possession
<input type="checkbox"/> Home Based Services	<input type="checkbox"/> Supports Coordination	<input type="checkbox"/> School to Careers
<input type="checkbox"/> FCM Specialized	<input type="checkbox"/> Head Start	<input type="checkbox"/> Crisis Intervention Program (CIP)
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Healthy Start Family Skills	<input type="checkbox"/> CSS Offender Group
<input type="checkbox"/> Respite	<input type="checkbox"/> On-call Crises Services	<input type="checkbox"/> Substance Abuse Treatment
<input type="checkbox"/> Infant Mental Health	<input type="checkbox"/> SED-Waiver	<input type="checkbox"/> Domestic Violence Interventions
<input type="checkbox"/> Outreach	<input type="checkbox"/> Multi-systemic Therapy-MST	<input type="checkbox"/> Inpatient Hospitalization
<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Psychiatric Services	<input type="checkbox"/> Partial Hospitalization
<input type="checkbox"/> Youth Engagement	<input type="checkbox"/> DHS Prevention Services	<input type="checkbox"/> Other: _____

23. Services & supports that parent/guardian and/or siblings are presently receiving: Attach additional information to referral.

Recipient	Service/Support

Section III: To be completed by Liaison, Mental Health Therapist/Clinician or Referral Source

24. Child's Diagnostic Information:

- Date of most recent multi-axial diagnostic evaluation? (*mm,dd,yyyy*) ___/___/_____
- Who provided the diagnosis?
 - Child Psychiatrist
 - Child Psychologist
 - Primary Care Physician
 - Other: (*please specify* _____)
 - General Psychiatrist
 - General Psychologist
 - Licensed/Limited Licensed Clinical Professional

25. Primary Diagnosis: Please use ICD-10 Codes with Diagnosis and Disorder name.

1st _____ 2nd _____
 3rd _____ 4th _____

26. Provisional Diagnosis:

1st _____ 2nd _____

27. Medical Diagnosis:

1st _____ 2nd _____

28. CAFAS or PECFAS Score: _____ Date of determination: _____ (must be within last 90 days)

29. What are the problems leading to referral for CFP Service? (*Select all that apply*)

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Conduct/delinquency-related behaviors (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away sexual assault, fire setting, cruelty to animals, truancy, police contact) <input type="checkbox"/> Intellectual disabilities <input type="checkbox"/> Hyperactive and attention-related behaviors (including hyperactive, impulsive, attentional difficulties) <input type="checkbox"/> School/Educational performance <input type="checkbox"/> Depression (including major depression, dysthymia, sleep disorders, somatic complaints) <input type="checkbox"/> Anxiety (including fears and phobias, generalized anxiety, social avoidance, obsessive compulsive disorder, post-traumatic stress disorder) <input type="checkbox"/> Adjustment-related issues (including changes in behaviors or emotions in reaction to a significant life stress) <input type="checkbox"/> Suicide related thoughts or actions (including suicide ideation, or suicide attempt) Self-injury (self-injurious behavior, hair pulling, cutting, etc.) <input type="checkbox"/> Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors) <input type="checkbox"/> Substance use, abuse, and drug dependency behaviors <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Eating disorders (including anorexia, bulimia) <input type="checkbox"/> Sleeping problems | <ul style="list-style-type: none"> <input type="checkbox"/> Current home unable to meet child's needs <input type="checkbox"/> Maltreatment (child abuse and neglect) <input type="checkbox"/> Behavioral concerns (including aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of overactivity) <input type="checkbox"/> Excessive crying/tantrums <input type="checkbox"/> Persistent noncompliance (when directed by caregivers/adults) <input type="checkbox"/> Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior) <input type="checkbox"/> Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech, and language delay) <input type="checkbox"/> Separation problems <input type="checkbox"/> Feeding problems (including failure to thrive) <input type="checkbox"/> Excluded from preschool of childcare due to behavioral or developmental problems <input type="checkbox"/> Attachment problems <input type="checkbox"/> Other concerns/issues that are related to child's health (cancer, illness, or disease-related problems) <input type="checkbox"/> Other please specify: _____ |
|--|---|

Send to CFP Service Coordinator, DeWanna Lancaster, with initial assessment and most recent quarterly (fax: 616.336.3593).

Community Family Partnership Services
CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION BETWEEN ORGANIZATIONS

I hereby authorize Network180, Arbor Circle, and Wedgwood, to facilitate a referral for CFP System of Care services for the _____ family with the Kent County Wraparound Community Team which may consist of:

ORGANIZATION

Network180	Kent ISD	Parent Support Partners	WMPC – West Michigan
Arbor Circle	Kent County Court	Department of Health &	Partnership for Children
Wedgwood Christian Services	Youth Advocate	Human Services	

1) INFORMATION TO BE EXCHANGED:

a. Information about the family's needs and previous services related to the Wraparound process and engaging a parent support partner. This may include information related to mental health, substance abuse and/or information about serious communicable diseases (HIV/AIDS, Tuberculosis, and Venereal Disease) if this information directly affects the Wraparound plan or parent support partner engagement process.

2) THIS INFORMATION IS TO BE USED ONLY FOR THE FOLLOWING PURPOSE:

- To request initial authorization of Wraparound Services and Parent Support Partner.
- Wraparound plan review for compliance with Michigan's Best Practice Values and the Wraparound Process components.
- When the child and family team need additional information regarding strategies and financial resources.
- To request continuation of services at six-month intervals this must occur for compliance of contract obligations.

Further release of this information is prohibited. Any person receiving information from the Wraparound Coordinator shall be so advised.

INITIAL HERE: ____ I have read this form and/or have had it read to me and explained in language that I can understand. I authorize the release of this information to the organizations listed above.

INITIAL HERE: ____ I give permission for my Wraparound Coordinator and/or Parent Support Partner to communicate information to me regarding my child and my family via encrypted email. I understand that this decision will have no impact on my ability to receive services.

La Community Family Partnership (CFP) proporciona atención a las familias mediante la coordinación de servicios y ayudas con agencias del Condado de Kent. Esto incluye servicios Wraparound, Parent Support Partners y ayudas entre iguales. La CFP se coordina con agencias que trabajan en los ámbitos de salud mental, sistema judicial para menores, protección a la infancia y escuelas; por ejemplo: Arbor Circle, Wedgwood Christian Services y Wellspring Lutheran Services.

Como parte de su participación con la CFP, se realizará una revisión de los expedientes del cliente, como asimismo de las encuestas/entrevistas, a fin de comprender el impacto de los servicios de la CFP. La CFP ha contratado al Community Research Institute (CRI) [Instituto de Investigación Comunitaria] para evaluar los servicios de la CFP.

El objetivo de la evaluación de la CFP es comprender si los servicios de la misma son efectivos y si necesitan cambios para ayudar mejor a las familias a alcanzar sus objetivos.

La evaluación de la CFP utiliza tres tipos de información a la que usted estará consintiendo:

- Expedientes del cliente provenientes de network180: Sus formularios o expedientes de información personal y médica de network180 serán compartidos con el CRI. Esto incluye información sobre formularios de derivación, ingreso, salida y otros formularios administrativos y del programa. Esto también incluye servicios y diagnósticos de la CFP.
- Encuestas/Entrevistas TRAC: Cada 6 meses, como parte de sus servicios Wraparound, a usted se le harán algunas preguntas sobre la salud de su familia y su satisfacción con los servicios Wraparound. Siempre se le preguntará si le gustaría participar.
- Observaciones TOM: Una observación general de los servicios Wraparound de su familia, para ver si el equipo de Wraparound está proporcionando los mejores servicios a su familia. Siempre se le preguntará si le gustaría participar.

El CRI mantiene su información de manera confidencial. Los resultados de la evaluación no son identificables. El CRI comparte los resultados e informes del proyecto con la CFP. La CFP valora a las familias y los resultados, y publicará dichos resultados con aliados, a fin de que comprendan la efectividad de los servicios.

Al firmar este formulario:

- Yo entiendo que, he leído este formulario o este formulario me ha sido leído.
- Autorizo el uso de esta información por el Community Research Institute

Nombre(s) de(l) (los) niño(s)/joven(es) (letra de imprenta, por favor):	network180 ID:

Ser completado por el cuidador/la cuidadora/el guardián/la guardiana:

Nombre de la persona a cargo / del tutor (letra de imprenta, por favor): _____

Firma de la persona a cargo / del tutor (por favor, firme): _____

Fecha: |__|/|__|/|__|_|

Exchange Obtained by: _____

STOP: *Send to CFP Service Coordinator, DeWanna Lancaster, with initial assessment and most recent quarterly (fax: 616.336.3593)*

Section III: *To be completed by CFP Service Coordinator*

1. Date received referral: _____

2. Date of Community Team Presentation: _____

3. System of Care enrollment status:

Child is receiving, or has received, a mental health service but is NOT eligible for additional CFP services (Wraparound or parent support partner).

Explanation: _____

Youth referred to other mental health service: _____

Youth referred to other community resource: _____

Child has received a system of care service (wraparound or parent support partner) and is eligible for additional services but will NOT be receiving any additional services.

Child is eligible for CFP Services (wraparound or parent support partner)

4. Has a diagnostic evaluation been done as part of the intake into the System of Care program? Yes No

5. Service Youth/Child authorized to receive (*select all that apply*):

Wraparound Parent Support Partner SED Waiver DHHS Wraparound

6. Assigned Provider: _____

7. Funding Stream: Medicaid SEDW Mental Health General Fund DHHS Wraparound

JJ – County Child Care Funds DHHS – County Child Care Funds

STOP: *Send to assigned provider wraparound facilitator or Parent Support Partner (if applicable) and upload to CRI*