CFP SERVICE REFERRAL FORM

CFP Eligibility Criteria for DHHS Wraparound

- ☐ **At-risk for removal due to abuse/neglect**
- ☐ **Minimum CAFAS score of 40**
- ☐ **Multi-system involvement**
- ☐ **Open CPS case Category I, II or III**

***Consult your DHHS Supervisor/Liaison with questions on potential referrals.**
PLEASE SUBMIT A DHHS CONTRACTED SERVICES REFERRAL FORM WITH REFERRAL AS REQUIRED TO AUTHORIZE SERVICES

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: _____

DeWanna Lancaster, *CFP Service Coordinator* 616.204.4321 Dewanna.lancaster@network180.org

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

14. Indicate the systems that the child is <u>presently</u> 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

Worker/Agency: _____ 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 Workers 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
☐ Food Stamps
☐ MI Child
☐ Supplemental Security Income- SSI
☐ Women, Infant, and Children- WIC
☐ Private Insurance
☐ Temporary Assistance to Needy Families-TANF
☐ Children's Health Insurance Plan-CHIP

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

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

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

☐ Individual Therapy	☐ Youth Enhancement	☐ Parenting classes
☐ Case Management (mental health)	☐ Dialectal Behavior Therapy	☐ CHILL
☐ Family Therapy	☐ PMTO	☐ ABC
☐ Group Therapy	☐ Trauma Focused CBT	☐ Minors in Possession
☐ Home Based Services	☐ Supports Coordination	☐ School to Careers
☐ FCM Specialized	☐ Head Start	☐ Crisis Intervention Program (CIP)
☐ Community Living Supports	☐ Healthy Start Family Skills	☐ CSS Offender Group
☐ Respite	☐ On-call Crises Services	☐ Substance Abuse Treatment
☐ Infant Mental Health	☐ SED-Waiver	☐ Domestic Violence Interventions
☐ Outreach	☐ Multi-systemic Therapy-MST	☐ Inpatient Hospitalization
☐ Intensive Outpatient	☐ Psychiatric Services	☐ Partial Hospitalization
☐ Youth Engagement	☐ DHS Prevention Services	☐ 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 ☐ General Psychiatrist
☐ Child Psychologist ☐ General Psychologist
☐ Primary Care Physician ☐ Licensed/Limited Licensed Clinical Professional
☐ Other: (*please specify* _____)

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)*

☐ 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)
☐ Intellectual disabilities
☐ Hyperactive and attention-related behaviors (including hyperactive, impulsive, attentional difficulties)
☐ School/Educational performance
☐ Depression (including major depression, dysthymia, sleep disorders, somatic complaints
☐ Anxiety (including fears and phobias, generalized anxiety, social avoidance, obsessive compulsive disorder, post-traumatic stress disorder)
☐ Adjustment-related issues (including changes in behaviors or emotions in reaction to a significant life stress)
☐ Suicide related thoughts or actions (including suicide ideation, or suicide attempt) Self-injury (self-injurious behavior, hair pulling, cutting, etc.)
☐ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
☐ Substance use, abuse, and drug dependency behaviors
☐ Learning disabilities
☐ Eating disorders (including anorexia, bulimia)
☐ Sleeping problems
☐ Current home unable to meet child's needs
☐ Maltreatment (child abuse and neglect)
☐ Behavioral concerns (including aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of overactivity)
☐ Excessive crying/tantrums
☐ Persistent noncompliance (when directed by caregivers/adults)
☐ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
☐ Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech, and language delay)
☐ Separation problems
☐ Feeding problems (including failure to thrive)
☐ Excluded from preschool of childcare due to behavioral or developmental problems
☐ Attachment problems
☐ Other concerns/issues that are related to child's health (cancer, illness, or disease-related problems)
☐ 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:
   a. To request initial authorization of Wraparound Services and Parent Support Partner.
   b. Wraparound plan review for compliance with Michigan's Best Practice Values and the Wraparound Process components.
   c. When the child and family team need additional information regarding strategies and financial resources.
   d. 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:

1. 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.
2. 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.
3. 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*