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: (_____) _____

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

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 <u>presently</u> receiving services or supports: (*Please fill out information completely)*

☐ 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 (past and current): **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: _____ Email:_____

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 <u>currently</u> 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 <u>prior</u> 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 mental health 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, most recent quarterly, registration and financial forms (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 Partnership for Children
Arbor Circle	Kent County Court	Department of Health & Human Services	
Wedgwood Christian Services	Youth Advocate		

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.

The Community Family Partnership (CFP) provides care for families by coordinating services and supports with agencies in Kent County. This includes Wraparound services, Parent Support Partners, or peer-to-peer supports. CFP coordinates with agencies that work in mental health care, juvenile justice, child welfare, and schools. For example, Arbor Circle, Wedgwood Christian Services, and Wellspring Lutheran Services.

As part of your participation with CFP, client records review and surveys/interviews will be done to understand the impact of CFP services. Iteration Evaluation has been hired to evaluate CFP. The goal of the CFP Evaluation is to understand if CFP services are effective and if they need to be changed to best help families reach their goals.

The CFP evaluation uses three types of information that you will be consenting to:

1. Client records from network180: Your network180 personal and health information forms or records will be shared with Iteration Evaluation. This includes information on the referral, intake, exit, and other administrative and program forms. This also includes CFP services and diagnoses.
2. TRAC Surveys/Interviews: Every 6 months, as a part of your Wraparound services, you will be asked some questions about your family's health and your satisfaction with Wraparound services. You will always be asked if you would like to participate.
3. TOMs observations: An overall observation of your family's Wraparound services to see if the Wraparound team is providing the best services to your family. You will always be asked if you would like to participate.

Evaluation procedures are designed to keep your information confidential. The evaluation results are not identifiable. Iteration Evaluation shares project results and reports with CFP. CFP values families and the results and will publish the results with partners so they understand the effectiveness of the services.

By signing this form:

- I understand that I have read this form or it has been read to me.
- I authorize the release of this information to Iteration Evaluation.

Names of Children/Youth (please print):	network180 ID:

To be completed by Caregiver/Guardian:

Caregiver/Guardian Name (please print): _____

Caregiver/Guardian Signature (please sign): _____

Date signed: | _ _ | / | _ _ | / | _ _ _ _ |

Exchange Obtained by: _____

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

Section IV: *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 (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 ☐ SED Waiver ☐ DHHS Wraparound
6. Assigned Provider: _____
7. Funding Stream: ☐ Medicaid ☐ SEDW ☐ Mental Health General Fund ☐ DHHS Wraparound
   ☐ Juvenile Justice – County Child Care Funds ☐ DHHS – County Child Care Funds