network180

WRAPAROUND REFERRAL FORM

Eligibility Criteria for Wraparound

A child/youth ages 0-20 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:

- ☐ is involved in multiple child/youth serving systems
- ☐ is 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
- ☐ has risk factors that exceed capacity for traditional community-based options
- ☐ has numerous providers that are serving multiple children/youth in the family and the identified outcomes are not being met

Indicate the service(s) you are requesting on behalf of the child/youth/family:
☐ Wraparound ☐ SED Waiver (meets criteria for State Psychiatric Hospital)
Medicaid status is active and was verified prior to referral: ☐ Yes - CONTINUE ☐ No, but youth is confirmed to be in foster care, on probation or the family has an active case with CPS. If so, please consult with Court/DHHS liaison prior to making this referral.

Section I – Demographics and System Involvement: *to be completed by referring party.*

1. **Child/Youth Name:** _____
   Last **First** **MI**
2. **Child/Youth Date of Birth:** *(mm/dd/yyyy)* __ __/ __ __ / __ __ __ __ **Network180 (CMH) Number:** _____
3. **What sex was the youth assigned at birth, on the original birth certificate?** ☐ Male ☐ Female
   Current Gender Identity: how does the youth describe themselves? (check one)
   ☐ Male ☐ Female ☐ Transgender ☐ Does not identify as female, male, or transgender
   Sexual Orientation: ☐ Heterosexual/Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown/Other
4. **Which best describes the child?** Is he/she… *(select all that apply)*
   ☐ American Indian ☐ Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
   ☐ Asian ☐ White or Euro-American ☐ Hispanic/Latin ☐ Other please specify: _____
5. **Primary language spoken in client's home:** _____ **Interpreter needed?** ☐ Yes ☐ No
6. **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/youth's residence at time of referral: _____ Zip code: _____
   Phone number of child/youth's residence at time of referral: (____) _____

7. Name of legal guardian or responsible party: _____

Address: _____

Relationship to child/youth: _____ Phone: (_____) _____

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

Section II – Support Services: *to be completed by referral source or clinician in partnership with family during family meeting.*

9. Indicate the systems that the child/youth 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

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

What school does the child/youth attend? _____ Child/Youth's current grade**:** _____

Special Education: ☐ LD ☐ EI ☐ CI ☐ Other (specify) _____ ☐ Speech/Hearing Impaired ☐ N/A

School Contact & Role: _____ Phone: (_____)_____

Medical: ☐ Child/Youth is healthy (Circle one): YES NO ☐ Child has an ongoing medical condition requiring coordination (diabetes, cancer, severe asthma, etc.)

Describe Condition: _____

Coordinating Physician/Specialist: _____ Phone: (_____)_____

☐ Other Community Supports

Type: _____ Phone: (_____) _____

10. 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 referral).

Number of placements (past and current): **Foster Care** _____ **Residential** _____ **Psychiatric Hospitalizations** _____

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

11. Is the child/youth at risk of Out-of-Home placement or placement in a more restrictive setting? ☐ Yes ☐ No **If yes specify risk:**

_____

_____

12. Describe prior services/supports that the child/family has utilized in the past and if they successfully completed:

_____

_____

13. Are the parent/guardian and/or siblings presently receiving services and/or supports? ☐ Yes ☐ No

Attach additional information to referral.

Recipient	CHM#	Service/Support

Name of person initiating referral: _____ Organization: _____

Supervisor Signature: _____ Date: _____

Source of referral: ☐ Juvenile Justice ☐ DHHS ☐ 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 Network 180 Clinical Liaison with most recent USP. Mental Health Therapists continue.*

Section III – Clinical Information: *to be completed by Mental Health Clinician, or Referral Source.*

14. Child/Youth's Diagnostic Information: (must include ALL supporting documentation of information requested below)

- Date of most recent mental health diagnostic evaluation? *(mm/dd/yyyy)* __ __/ __ __ / __ __ __ __
- Who provided the diagnosis/credentials? Name: _____ Credentials: _____

15. Primary Diagnosis: Please use ICD-10 Codes with Diagnosis and Disorder name. (ie. F43.0 PTSD)

1st _____ 2nd _____

3rd _____ 4th _____

16. Medical Diagnosis:

1st _____ 2nd _____

17. ☐ CAFAS or ☐ PECFAS Score: _____ Date of determination: *(mm/dd/yyyy)* __ __/ __ __ / __ __ __ __ (must be within last 90 days)

CAFAS/ PECFAS Sub scores:

School	Home	Community	Behavior Towards Other
Mood/Emotions	Self-Harm	Thinking	Substance

18. Summarize the problems leading to this referral including specific behavioral/emotional concerns and crisis/safety concerns:

_____

_____

_____

_____

_____

STOP: *Send to:* ***ATTN: Administrative Assistant Angela Wisner,*** *with initial assessment, most recent quarterly and updated registration forms (FAX: 616-336-2475).*

Section IV: *To be completed by Community Team.*

1. Date received referral: *(mm/dd/yyyy)* __ __/ __ __ / __ __ __ __
2. Date of Community Team Presentation: *(mm/dd/yyyy)* __ __/ __ __ / __ __ __ __
3. Service Youth/Child authorized to receive *(select all that apply)* :
   ☐ Wraparound ☐ SED Waiver ☐ DHHS Wraparound
4. Assigned Provider: _____
5. Funding Stream: ☐ Medicaid ☐ SEDW ☐ Mental Health General Fund ☐ DHHS Wraparound
   ☐ Juvenile Justice – County Child Care Funds ☐ DHHS – County Child Care Funds

CMH # _____

Network 180
CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION BETWEEN ORGANIZATIONS

I hereby authorize Network180, Arbor Circle, and Wedgwood, to facilitate a referral to Wraparound services for the (*Name, date of birth*) _____ 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/or 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 and/or parent support partner engagement process.

2) THIS INFORMATION IS TO BE USED ONLY FOR THE FOLLOWING PURPOSE:
   a. To request initial authorization and continuation of Wraparound Services
   b. Wraparound plan review for compliance with Michigan's Medicaid Manual
   c. When the child and family team need additional information regarding strategies and financial resources

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 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.

Network180 contracts with service providers in Kent County. Arbor Circle and Wedgwood Christian Services to facilitate the Wraparound process.

To be completed by Caregiver/Guardian:

Caregiver/Guardian Name (please print): _____

Caregiver/Guardian Signature (please sign): _____

Date signed: *(mm/dd/yyyy)* _ _ / _ _/_ _ _ _

Exchange Obtained by: _____