WRAPAROUND SERVICES REFERRAL

As you refer, please do the following:

☐ 1. Obtain supervisor's signature.

☐ 2. Make sure necessary releases are signed by parent, guardian, court or DHS as appropriate to wardship status.

☐ 3. Attach recent case summaries, releases and other relevant documents.

☐ 4. Send completed referral form via secure email to: Maresa Keels : Maresa.Keels@oakland.k12.mi.us
If you have question, please call 248-209-2407.

Referring Agency: _____ Date of Referral: _____

Referring Person (Signature & Date) _____Phone _____

Organization Referring Person's Supervisor (Signature & Date) _____

Family Name: _____

Address: _____ Phone: _____

Identified Consumer: _____

CMH Con ID Number:_____ Date of Birth _____

Potential SED Waiver: ___Pilot ___Traditional ___N/A

School & grade currently attending: _____Special Education Eligibility? _____

Child's current mental health diagnosis: _____

History of Hospitalizations (dates and locations):
_____
_____

Past Protective Service referral: _____
(If yes, date(s) and classification)

Current Protective Service Involvement _____
(If yes, current classification)

Protective Services Worker assigned, name and phone number:_____

Number of days out of home in the last year (residential, psychiatric, juvenile detention, foster care):_____

Number of days out of school (truancy; unexcused/suspension/expulsion) in the last school year:_____

Has there been any court involvement with the child or family? If so, what type? _____

Is there a court worker assigned? If so, please give their name and phone number._____

Date of most recent CAFAS (must be within 30 days) _____

CAFAS Scores:

School Work: _____
Home _____
Community: _____
Behavior Toward Others: _____
Moods/Emotions: _____
Self-Harmful Behavior:_____
Substance Use: _____
Thinking: _____
Total for Youth Subscales: _____

Care Giver Subscales:
Material Needs: _____
Familial/Social Support:_____

Please check all that apply and give explanation for each. Youth must meet two or more of the Following Criteria:

____Youth Involved in Multiple Systems. (Check those that apply)
__Mental Health
__Special Education
__Juvenile Justice
__Substance Abuse Treatment
__Foster Care/Protective Services
__Other: Please Explain _____

____ Risk of Out of Home Placement or currently in Out of Home Placement
_____
_____
_____
_____
_____

____Youth has been served through other mental health services with minimal improvement.
_____
_____
_____
_____
_____

____The risk factors exceed capacity for traditional community-based options.
_____
_____
_____
_____
_____

____Numerous providers are serving multiple children in the family and the outcomes are not being met.

_____
_____
_____
_____
_____

Describe the intended need to be met or gap you are trying to fill by making a referral for Wraparound Services: (attach additional pages if necessary)

_____
_____
_____
_____

On which specific CAFAS subscales are you asking Wraparound Staff to focus:

_____
_____

Of the specific CAFAS subscales, what types of interventions would you like the Wraparound Child and Family Team to explore:

_____
_____
_____
_____
_____

Please describe the referred child's challenges that may be occurring in the home, school or community.

_____
_____
_____
_____
_____

ALTERNATIVES EXPLORED TO DATE, SERVICES PROVIDED & OUTCOMES:

_____
_____
_____
_____

Household Members (List all and relationships)	Birth Date	School (Grade and Special Education Eligibility)	Address/Current Placement

WHAT COMMUNITY RESOURCES ARE <u>CURRENTLY OR RECENTLY INVOLVED & COMMITTED?</u>

Agency	Committed (Y/N)	Phone	Staff Name

Date the referring clinician provided a description of the Wraparound process: _____

The family is willing to put together a team that consists of both informal supports (friends, extended family, neighbors, etc.) as well as formal supports such as professionals that may be providing service to family members.

Yes _____ No:_____

WHO COULD POTENTIALLY BE ON THE TEAM?

NAME	ADDRESS	PHONE	RELATIONSHIP

Comments:
_____
_____
_____
_____

For Office Use

Date Referral Received _____ Date Reviewed by Community Team: _____

_____Intake approved for Wraparound
_____Intake approved with recommendations
_____Intake not approved.

Comments:_____
_____
_____
_____

_____ _____
Circuit Court/Family Div. Oakland Schools

_____ _____
Easter Seals DHS

_____ _____
OFS Consumer/Parent Support

_____
Parent Support

Assigned to: _____

08/16
Previous Additions Obsolete

Authorization to Release/Request for an Individual's Health Information

Consumer's Name	Date of Birth	Record Number
Address		**Phone Number**

I hereby request access to the protected health information ("PHI") record from this date:_____to this date: _____ maintained or created by the provider named below to the recipient named below.

☐ Progress/Case Notes ☐ Other:_____

☐ Billing Records

☐ Entire health record (excluding psychotherapy notes)

Delivery of Records:

☐ I will pick up my own records

☐ Please fax my records to the number below.

☐ Please mail copies of my records to the address below.

	Records From	Records To
Name		
Address		
Phone		
Fax		

Purpose of Request:

☐ Consumer's Request ☐ Referral

☐ Dispute ☐ Other: Wraparound Referral and Intake Screening

By signing below, I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Oakland may not condition the provision of treatment or payment for my care on my signing of this authorization.
- The information disclosed pursuant to this authorization may be redisclosed by the recipient any may not be protected under the HIPAA regulations.

Consumer's Full Legal Name	Date of Birth
Signature of Consumer/Parent/Legal Representative	**Date**

*****Office: Please retain a copy of this form for six (6) years.*****