Assigned:

WOOD COUNTY HUMAN SERVICES

Referral for Children’s Long Term Support (**CLTS**) Waiver Program, Family Support Program (**FSP**), Coordinated Services Team (**CST**) & Children’s Comprehensive Community Services(**CCS**)

Date of Referral:

Which program the individual is being referred to? Select all that apply:

CLTS: [ ]  CCOP: [ ]  CST: [ ]  Children’s CCS: [ ]  Unknown: [ ]

**Information on individual making referral:**

Name:  Agency (if appropriate):

Address:

Phone number:

Relationship to Child Being Referred:

Does Parent/Guardian(s) know child is being referred for voluntary program/service(s)?

These programs are voluntary. Are the child and parent/guardian(s) willing to participate or at least learn more about programming options available?

**Information on individual being referred:**

Name of Child (Last, First, Middle Initial):

D.O.B.: Age**:**  Gender:  Social Security Number:

Address of Child:  Wood County Resident: Yes: [ ]  No: [ ]

Phone Number(s):

Others Living in Home with Child/Current Living Situation:

**Parent Guardian Information:**

Name of Parent/Guardian(s):

Address:

Phone Number:

Best Time to Contact Parent/Guardian(s):

**Insurance information on individual being referred**:

Primary insurance (if known):

Do they have a source of MA? MA Number (if available):

If they have a source of MA, what source is it?

SSI: [ ]  Katie Beckett: [ ]  Badger Care: [ ]  Unknown: [ ]  Other: [ ]

**Medical information on individual being referred**:

What are the child’s current diagnoses (physical, mental health, or developmental diagnosis)?

Which doctors/physicians does the child currently see?

Child’s current medications and doses:

Has child been hospitalized in the past?

 If so explain when, where, and why?

Is the child involved in other Human Services Agencies (CHIPS, JIPS, Delinquent, etc.)?

**School information on individual being referred**:

Where is child attending School?  What grade is the child in?

Who is the school contact person (name & phone number if known)?

Describe school performance/attendance/services received:

Does the child have an Individualized Educational Plan (IEP)?

If there is an IEP, what does the child qualify under (select all that apply)?

[ ]  Learning Disability (LD) [ ]  Cognitive Disability (CD) [ ]  Orthopedically Impaired

[ ]  Hearing Impairment

[ ]  Visual Impairment

[ ]  Speech and Language (SPL)

[ ]  Other Health Impairment (OHI)

[ ]  Emotional/Behavioral Disability (EBD) [ ]  Significant Developmental Delay

[ ]  Educational

[ ]  Autism

[ ]  Unknown

[ ]  Other:

**Questions to help determine need**:

Has the child had a Functional Screen Completed on him/her in the past for any of these programs?

Is the child at risk for out-of-home/institutional placement; or is currently in an out-of-home placement?

Has the child had persistent obstacles to service access?

Is there a need for service coordination?

Has the child been involved in multiple direct services (e.g. mental health therapy, medication monitoring, special education, juvenile justice, child protective services, alcohol and/or other drug services, etc.)?

 \*If yes, list services if not already provided in the referral:

Have other interventions not been successful over time?

 \*If yes, list unsuccessful interventions attempted:

Being as specific as possible, why are you referring this child, what needs does this child have that are not currently being met, and/or what services are being requested?

**You can make a referral by calling 715-421-4244 or e-mailing referral to** **crisisintervention@co.wood.wi.us**