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**](mailto:crisisintervention@co.wood.wi.us)