Manitowoc County Human Services Department

REFERRAL FOR CHILDREN SERVICES

Please have referral form fully completed for review and assignment.
Incomplete referrals cannot be processed.

Check Program Referring to:

☐(CLTS) Children's Long Term Support
☐(CST) Coordinated Services Team
☐(CCS) Comprehensive Community Services **(requires parental/legal guardian consent)**
☐Outpatient Psychotherapy
☐AODA Counseling
☐ (CST) Family Find/Families First Referral

Note: If you are in doubt which program please check those you feel most appropriate. The Children's Referral team will review details in referral and route appropriately.

Does Child have Medical Assistance (MA): ☐YES ☐ NO ☐Katie Beckett ☐SSI
Private Insurance: ☐YES ☐ NO
Does client need a financial intake? **(required for CCS)** ☐ Yes ☐ No
Has an intake been scheduled? ☐ Yes ☐ No

Date of Referral:

Referral Source Name:

Referral Source Address:

Referral Source Phone Number:

Child's Name:

Preferred Name:

Address:

DOB: Age:

City/State:

Sex at Birth: ☐M ☐F
Gender Identity:

Telephone:

Parent/Guardian/Caregiver Information:

#1 Name:

DOB:

Address:

Phone Number:

#2 Name:

DOB:

Address:

Phone Number:

Person authorized to consent for Mental Health Treatment:

Other Children in the home:

Name:		DOB:	
Name:		DOB:	
Name:		DOB:	
Name:		DOB:	

Type of Disability: ☒Developmental ☐Physical ☐Autism ☐Medical ☐Mental Health

*If physical disability, developmental disability, or autism, refer to CLTS
*If only mental health, refer to CCS if outpatient has been attempted and not adequate to meet the child's needs

Diagnosis - Who Diagnosed/When?:

History of Mental Health Treatments and Dates:

Reason for termination:

Behavioral Concerns:

☐Homicidal Statements When:_____ Frequency:_____
☐Suicidal Statements When:_____ Frequency:_____
☐Suicide Attempts When:_____ Frequency:_____
☐Mental Health Hospitalizations When:_____ Frequency:_____
☐Self Harm
☐Running Away
☐Tantrums/meltdowns
☐Defiance
☐Stealing
☐Sexual Acting Out
☐Bullying
☐Destruction of Property
☐Physical Aggression
☐Police Contact Explain:_____ Charged?☐Yes ☐No
☐School suspensions/expulsions/missing school: Frequency:_____

Known Medical Conditions:_____

Drug/Alcohol Information:

Currently using: ☐Yes ☐No (if yes please list frequency & route of use, last date of use)

☐Currently using tobacco.

☐Currently using alcohol.

☐Currently using Marijuana

Other concerns not listed:

Current Medications:

Current Services:

School - Grade: IEP:☐YES ☐NO

Pediatrician -

Psychiatrist -

Psychotherapist -

PLEASE OBTAIN ALL RELEASES OF INFORMATION FOR RECORDS FROM PROVIDERS

Please check all that apply:

☐Use of multiple direct services (e.g. mental health, special education, juvenile justice, CPS, CASA)
Name of social worker(s)/other worker(s)_____
_____

☐At risk of or currently in an out-of-home placement/or in placement

☐Parents are willing to be involved in the team process

I, the undersigned, understand that a referral is being made on behalf of _____ (client name)

for: ☐AODA Counseling ☐Psychotherapy ☐CCS ☐CLTS ☐CST.

I further understand that participation in any of these services is voluntary and requires a commitment to attending appointments and completing any homework assignments that are part of psychotherapy.

Parent/Guardian #1: _____

Youth (age 14 or older): _____

Parent/Guardian #2: _____

Youth (age 14 or older): _____

☐ Referral by phone call

If signatures are not possible, please attach documentation of a phone contact indicating the parent/guardian is aware of and in agreement with this referral.

All referrals emailed to the following for review:
child.ref@manitowoccountywi.gov

AUTHORIZATION FOR USE AND DISCLOSURE OF PHI AND NON-PHI INFORMATION

Person whose information is authorized to be used or disclosed:

Name: _____ Date of Birth: _____
Street Address: _____
City, State, Zip: _____ Telephone Number: _____

Person or entity authorized to use or disclose information:

Name: _____
Street Address: _____
City, State, Zip: _____

Person or entity authorized to receive information:

Name: Manitowoc County Human Services Dept.
Street Address: 926 South 8th Street, P.O. Box 1177
City, State, Zip: Manitowoc, WI 54221-1177

I authorize the following information to be used or disclosed:

Protected Health Information (PHI)

- ☐ Intake / Initial Assessment Psychiatric / Psychological Evaluations Medical
- ☐ Evaluations / Physical Exams Laboratory Reports
- ☐ Sexually Transmitted Diseases
- ☐ HIV (AIDS)
- ☐ Social History
- ☐ Treatment Plan / Reviews Medications Prescribed
- ☐ Staffing Notes / Progress Notes Discharge Summary
- ☐ Other (Specify): _____
- ☐ Substance Abuse Assessment/Diagnosis
- ☐ Substance Abuse Treatment Plan
- ☐ Substance Abuse Progress Notes
- ☐ Substance Abuse Discharge Summary
- ☐ Service Coordination Assessment
- ☐ Service Coordination Plan
- ☐ Service Coordination Case Notes

Non-PHI

- ☐ Child Abuse / Neglect Reports
- ☐ Financial Information
- ☐ Residential Records
- ☐ School Academic Records
- ☐ School Attendance Records
- ☐ School Behavior Records
- ☐ Vocational Records
- ☐ Court Records
- ☐ Other --- Specify

_____
_____
_____

In compliance with Wisconsin law, which requires special permission to release otherwise privileged information, I expressly authorize the use or disclosure of health information and records pertaining to (check all that apply):

- ☐ Alcohol or Drug Abuse
- ☐ Developmental Disabilities
- ☐ Mental Health
- ☐ HIV test results
- ☐ Other (specify): _____

Reason or purpose for use or disclosure (check all that apply):

- ☐ At my request
- ☐ Further Medical Care
- ☐ Other (Specify): _____

This authorization permits the use or disclosure of health information for the period from:

_____ to _____

This authorization is valid until: (specify date or event)

_____

AUTHORIZATION

I am (check one) ☐ the person ☐ the authorized representative of the person whose information is authorized to be used or disclosed.

I have read both sides of this form. I have received a copy of this form. I understand the contents of this form. I agree that a photocopy or facsimile of this form is as valid as the original. This form accurately reflects my wishes and I authorize the use or disclosure of health and other information as described on this form.

Information about Authorized Representative:

Name: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____
Relationship of Authorized Representative:

_____

_____
Signature of Client or Authorized Representative

Date: _____

_____
Signature of client who is a minor 14 y/o or older

NOTICE OF RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization: You are not required to sign this authorization and you may refuse to do so. Manitowoc County may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on your decision to sign this authorization. However, it may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization. It may also condition the provision of research-related treatment on the signing of this authorization for the use and disclosure of protected health information created for research that includes treatment.

Right to Receive Copy of This Authorization: You have a right to receive a copy of this authorization if you choose to sign it.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: You have the right to inspect or copy the health information that you have authorized to be used or disclosed. You may arrange to inspect your health information or to obtain copies of your health information by contacting the Records Custodian for the person or entity authorized to disclose health information at the address and telephone number shown on the front of this form.

Right to Revoke This Authorization: You have the right to revoke this authorization at any time, except if this authorization was given as a condition of obtaining insurance coverage. If this authorization was given as a condition of obtaining insurance coverage, the insurer may have a right to contest a claim under the policy or to contest the policy itself. Revocation of this authorization must be made in writing to Manitowoc County. The written revocation will be effective on receipt *except* for any use or disclosure of health information that took place prior to its receipt.

Right to Notice Regarding Redisclosure: The health information used or disclosed pursuant to this authorization may be redisclosed by the recipient, and the redisclosed information may no longer be protected under the terms of this authorization.

Right to Notice of Marketing Activities: You will be informed of any direct or indirect payment that Manitowoc County receives as a result of the use or disclosure of your health information for marketing activities.

Notice Regarding HIV Test Results: HIV test results may be used or disclosed without authorization when required by law.