



CHILDREN WITH INTENSIVE NEEDS (CWIN) REFERRAL FORM
Children and families must reside in Montgomery County in order to receive services.

Please fill in all questions.

Date of referral _____ Child's Name _____ Gender M F

DOB _____ Age _____ Child's race & ethnicity _____

Child's current living situation (i.e.: parents, hospital, foster care, etc.) _____

Adoptive parents Yes No Siblings names and age _____

Name of school _____ Current attendance status? _____ Grade _____

Is he/she in Special Education? Yes No What is the education Code? _____

Are key school staff (i.e. guidance counselor, PW, psychologist) involved with this child/family? Yes No

Referral source name _____ Agency name _____

Relationship to child _____ Phone (w) _____ (cell) _____

Email address _____

Address of Referral Source _____ Zip Code _____

Parent/Guardian _____ Phone (h) _____ (cell) _____ (w) _____

Address of family _____ Zip Code _____

Parent/Guardian Email _____

Parent/guardian race & ethnicity _____ Language(s) _____

What is the child's insurance? MA # _____ Private None Care for Kids (MCHP)

Details about child's risk behaviors.

. Types of services requested (i.e. parenting, mentoring, out of home, etc.).

Has the child had a psychiatric hospitalization? Yes No Unknown How many times? _____

Where? _____ Dates/time frames hospitalized _____

Reason (i.e.: suicidal, aggression) _____

Name of current therapist & agency _____

Phone (w) _____ (cell) _____ How long with this therapist? _____

Name of current psychiatrist & agency _____

Phone (w) _____ (cell) _____ How long with this psychiatrist? _____

Mental Health diagnosis _____

Is the child taking any psychiatric medication? _____ Medication/reason _____

Any prior therapy or medication tried in the past? _____

Does the child have any major physical issues? _____

Is/was the child involved in any agency/system? DJS Child Welfare MCPS Other Unknown

Agency contact person _____ Phone (w) _____ (cell) _____

Is parent/guardian definitely interested in intensive in-home services from Wraparound, if eligible? Yes No

Does caregiver have needs that interfere with caring for child (i.e. Mental Health, physical, substance use-related, finances)? _____

What are the caregiver's strengths (i.e. resources, involvement, knowledge, housing stability, keeps appointments)?

Do the caregiver(s) and the child get along? _____

Please list 3 strengths that the child has: _____

Do you think the child is 'at risk' of needing an Out-Of-Home placement? Why? _____

Has a *licensed clinician* (therapist, psychiatrist) assessed the child as being 'at risk' of a Residential Treatment Center (RTC) placement? * Yes No

*Completion of a Clinical Recommendation Form may be requested with this application if child is at risk of RTC.

Any additional information that, would be helpful for us to know?

All information requested must be completed in order to process this referral. You need to fax CWIN Referral Form, and the Consent to Release Information together. Updated 2015

PLEASE SEND COMPLETED FORM TO ATTN: Kathy Boland, Resource Specialist, Local Care Team

FAX: 301-610-0148 PHONE: 301-354-4910; EMAIL: Kathy.boland@collaborationcouncil.org