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______________________

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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 (H) _____________ (cell) _______________

Phone (W) ______________________________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.

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

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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?

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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