VALLEY | CITIES
Behavioral Health Care

WISe (Wraparound with Intensive Services) Program

Thank you for your interest in the Valley Cities WISe Program. Please take a moment to read the information below.
We ask that you provide as much information known at this time to help ensure that we are able to process your referral in a timely manner.
If you have any questions please call our WISe Program Support Specialist at 206-408-5246.

WISe is a voluntary team-based planning process for youth with complex needs and their families designed to help produce better outcomes. Through WISe, youth receive intensive therapy, care coordination, peer support and other services to help them reach their goals. Participation in WISe will include:

- A team of individuals who are relevant to the well-being of a youth (family members, service providers, school staff, community members, and natural supports)
- Development and implementation of an individualized plan of care and treatment plan that will be monitored over the course of your time in WISe

Eligibility: Children/youth up to 21 years of age, who consent, along with their caregiver/guardian, to participate and who

· are Medicaid Eligible
· have concerning behaviors at home, school and in the community
· complete a Mental Health assessment and receive a MH diagnosis

What to expect during the referral process:

- WISe staff will contact the referent and youth/family to gather additional information to determine eligibility based on the Child and Adolescent Needs and Strength (CANS) Screen tool.
- Program Support Specialist will work with you and your family to discuss and resolve any barriers to WISe eligibility

Referral Checklist:

☐ All contact information including name, phone number and address is complete for the youth, parent/guardian and collaborative partners

☐The Authorization to disclose information is reviewed with the youth and parent/guardian, completed and signed by the youth if 13 years or older and/or the parent/guardian if the youth is under 13 years old.

☐Fax your completed Valley Cities WISe referral form to 253-856-1025. The WISe Program Support Specialist is available to receive WISe referrals by phone at 206-408-5246. Interpreters are available upon request.

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Referent Information					
Referring Person		**Phone**		**Agency Name**	
Relationship to Youth		**Email**		**Address**	

Client Information							
Youth's Name		**DOB**		**Age**		**Gender Pronoun**	
Ethnicity		**Primary Language**				**Interpreter Needed**	☐Yes ☐ No
Phone # 1	Please check one ☐Home ☐Work ☐Cell	**Phone # 2**	Please check one ☐Home ☐Work ☐Cell				
Resides With		**Relationship**					
Address	**Street address:** **City:** **State:** **Zip:**						

Healthcare Information		
Is the youth eligible for Medicaid? (check one)	☐ **YES** ☐ **NO**	**Provider One #:**
MCO/Insurance Company (select one)	☐ **Amerigroup** ☐ **Coordinated Care/Core Connections** ☐ **Coordinated Health Plan of WA** ☐ **Molina** ☐ **United Healthcare**	

Parent/Legal Guardian Information			
Name		**Relationship**	
Primary Language		**Interpreter Needed**	☐Yes ☐ No
Phone # 1	Please check one ☐Home ☐Work ☐Cell	**Phone # 2**	Please check one ☐Home ☐Work ☐Cell
Address	**Street address:** **City:** **State:** **Zip:**		
Email		I give permission to be contacted by email ☐Yes ☐No	

Household Members *(Siblings, foster children, relatives, non-related persons)*					
Name	**Age**	**Relationship**	**Name**	**Age**	**Relationship**

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Educational Information *Current or most recent school attended*			
School Name		**Home School District**	
IEP or 504 Plan (check one)	☐ YES ☐ NO If Yes, which one:	**Youth is Currently (circle one)**	☐**Enrolled** ☐**Suspended** ☐**Expelled**

Collaborative Partners			
Collaborative Partners	**Contact Person**	**Agency**	**Phone Number**
Mental Health			
Substance Use			
Special Education			
DCYF*			
Juvenile Justice			
DDA*			
Natural Support (s)*			
Other			

*see pg. 4 for additional information

Family Strengths **Describe the child and family strengths-** *(for example: traditions, activities enjoy doing together, specific talents, skills of the youth & family members)*

Reason for Current WISe Request *Please include symptoms and behaviors of the youth you are concerned about*	**Potential Risk Factors** *Please check all that apply to the best of your knowledge*
	In the last 30 days has the youth: ☐Had thoughts about suicide ☐Made a suicide attempt ☐Engaged in self-injurious behavior ☐Threatened or has been physically aggressive towards others ☐Run Away and if so, for how long?______

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Office use only:

Date Referral Received: ____________________ **Determination:** ______________ **Date determination made:** ___________________

VCBH WISe Enrollment Date: ___________________

Staff Assigned: Peer: ___________________________ **Facilitator:** ___________________________ **Clinician:** __________________________

Valley Cities ID: __________________

If applicable
Date New Request received ______________ ***Determination:*** ____________ ***Date determination made:*** _______________

*DCYF: Department of Children, Youth, and Families
*DDA: Developmental Disabilities Administration
*Natural Supports: Friends, Extended Family, Neighbor, etc

Please make sure to complete and sign the Authorization to Disclose and Redisclose Protected Health Information on the next page (page 5) with this referral

Authorization To Disclose and Redisclose Protected Health Information

Youth's Name: _______________________________________ Date of Birth: _________________ Age: ________

Valley Cities WISe (Wraparound with Intensive Services) represents an effort to implement system collaboration on behalf of at-risk children and youth through the on-going efforts of families, their supports, local child serving agencies and school districts.

I authorize the following entities to disclose and redisclose my health care information to and among themselves as applicable:

☒ Valley Cities WISe Program
☒ King County Integrated Care Network (a list of behavioral health providers is available on request)
☐ King County Juvenile Courts
☐ Washington State and King County Developmental Disabilities Administration
☐ Department of Children, Youth and Families
☐ ______________________________ School District (please write in the youth's home school district)
☐ ______________________________ Parent(s) or caregiver(s) of the youth named above
☐ ______________________________ Guardian(s) of the youth named above
☐ ______________________________ Other

The purpose of this authorized exchange of information is to:

- Determine eligibility for Valley Cities WISe Program
- Coordinate a planning process leading to the development of a child and family team and an individualized plan of care
- Evaluate the program and delivery of hi-fidelity wraparound

Information to be disclosed and redisclosed includes: Please check all appropriate boxes.

☐Name & date of birth	☐Current & past mental health treatment including dates and diagnosis	☐Juvenile justice including charges, court dates and probation, at-risk-youth, or truancy requirements.
☐Address & phone number	☐Current & past medical treatment including dates and diagnosis	☐Current or past out-of-home placements and related service planning from Children's Administration
☐School location, special education assessments & special education plans	☐Current & past substance use treatment including dates and diagnosis	☐Current or past assessments and service planning from Developmental Disabilities Administration

By signing this form, I understand:

- When I am asked to fill out this authorization, I am entitled to a copy.
- The information disclosed and redisclosed may contain information on my current/past: Mental health, drug or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2*.
- If I do not sign this authorization, it will not affect my ability to obtain health care services from the individual health care providers identified above, but my authorization is necessary for Valley Cities WISe (Wraparound with Intensive Services) to coordinate my care and services.
- **I have the right to revoke (to end) this authorization at any time. This must be communicated directly (verbally and/or in writing) to the Valley Cities WISe Program. Any revocation will not take effect if action has already been taken based on the original authorization.**
- **Without my express revocation, this authorization will expire 90 days after discharge from the program.**

Youth (13+ years) Signature: ____ Date: ______________________________

Parent/Guardian Signature: ____ Date: ______________________________

***If you are redisclosing information related to Substance Use Disorder or Treatment the information below must be included:**
42 CFR 2.32: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. **Consent of Minor (Age 13-17)**: A minor's signature is required to release information concerning chemical dependency or mental health conditions (42 CFR, Part 2; WAC 388-865, 45 CFR).