**Central Wisconsin Health Partnership**

**Comprehensive Community Services (CCS)**

**Referral Form**

**Initial Eligibility**

If you are considering making a referral to CCS, please review the following eligibility criteria:

*The individual MUST meet all of the following requirements:*

[ ]  Be a resident of Adams/Green Lake/Juneau/Marquette/Waupaca/Waushara County

[ ]  Have Medical Assistance (MA) or be eligible to receive MA

[ ]  Be seeking or receiving mental health and/or substance use services

*Within the past 12 months, has the individual:*

Been given a mental health or substance use diagnosis? [ ]  YES [ ]  NO

Accessed any of the following services? (please check all that apply):

[ ]  Crisis intervention services

[ ]  Outpatient mental health

[ ]  Outpatient substance use

[ ]  Inpatient psychiatric hospitalization(s)

[ ]  Inpatient substance use (e.g. detox)

[ ]  Emergency Room visits

[ ]  Other (please specify):

**Responsibility of Person Making the Referral**

A referral to CCS should be a *collaborative effort* between the individual making the referral, and the individual or family interested in CCS. The individual making the referral is requested to discuss and share information related to CCS with the prospective consumer. Resources may include, but are not limited to:

* CCS Brochure
* CWHP regional “CCS Consumer Handbook”: <http://www.cwhpartnership.org/regional-ccs-forms.html>
* The CCS page for consumers on the Wisconsin DHS website: <https://www.dhs.wisconsin.gov/ccs/consumers.htm>

[ ]  I have discussed the CCS program with the individual/family and they are interested in pursuing a referral to the program.

*Please continue on page 2 and return the completed referral form to:*

**Date of Referral:**

|  |  |
| --- | --- |
| Name |       |
| Phone |       |
| Relationship to consumer |       |

**Contact Information of Person Making Referral**

Referral Source: [ ]  Self [ ]  MH/AODA [ ]  CPS [ ]  CLTS [ ]  CSP [ ]  APS [ ] Medical

[ ]  School [ ]  ADRC [ ]  Other:

**Referral Information**

Medical Assistance: [ ]  Yes [ ]  No MA#:

|  |  |
| --- | --- |
| Name |       |
| DOB |       |
| SSN |       |
| Gender |       |
| Marital Status |       |
| Address |       |
| City/State/Zip |       |
| Home Phone |       |
| Alternate Phone |       |
| Parents Name(s) |       |

**Please complete the following to provide further information regarding potential client.**

Individual’s clinical diagnosis, name of diagnosing doctor, and how symptoms are manifested:

Please explain the type of services/assistance the consumer needs or is requesting:

Are there other services or supports not mentioned above that you think might be helpful:

Are there any health concerns for this individual:

Is the individual currently involved with other services or agencies:

[ ]  CPS [ ]  JJ [ ]  CLTS [ ]  APS [ ]  ADRC [ ]  MH Outpatient [ ]  AODA [ ]  CSP [ ] Crisis

[ ]  Other:

**Referral Consent**

By signing this document, I give my consent to be referred to the CCS program in       County.

Signature of individual being referred and/or their legal guardian

FOR CCS STAFF USE ONLY: PLEASE DO NOT WRITE BELOW THIS LINE

Date reviewed:

Is the individual eligible for CCS? [ ]  YES [ ]  NO

If “yes”, Service Facilitator assigned:

If “no”, what other services or supports was the individual referred to?

According to DHS 36.14(3)(b) *- If an applicant is determined to not need psychosocial rehabilitation services, they shall be given written notice of determination and referred to a non-CCS Program.* Date letter sent: