



MILWAUKEE COUNTY  
BEHAVIORAL HEALTH DIVISION  
COMMUNITY SERVICES BRANCH

*S*ERVICE *A*CCESS TO *I*NDEPENDENT *L*IVING (*SAIL*)

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9201 W. Watertown Plank Road

Milwaukee, WI 53226

(414) 257-8095

Fax: (414) 454-4242

Milwaukee County Community Services Branch proudly serves Milwaukee County residents ages 18-59 who are living with a severe and persistent mental illness which affects their ability to function successfully in the community. Thank you for considering our community-based services. Before proceeding with the SAIL referral, please review and complete the following checklist, which clarifies our target population.

Is the client a Milwaukee County resident?

Is the client between the ages of 18 and 59?

*If age 60 and over, a referral must first be made to the Aging Resource Center of Milwaukee County (414.289.6874). Please include a copy of the determination letter indicating Family Care ineligibility with the SAIL referral.*

*If under age 18, the client must be enrolled in Project O'YEAH or Wraparound/REACH. Please include a copy of the Plan of Care with the SAIL referral.*

Does the client have a severe and persistent mental illness that interferes with their ability to live successfully in the community?

*A severe and persistent mental illness is severe in degree and persistent in duration, resulting in a substantially diminished level of functioning in the primary aspects of daily living and difficulty coping with the ordinary demands of life. This may further lead to challenges in maintaining stability and independent functioning, requiring long-term treatment and support.*

If the individual being referred meets the target population, please proceed with completion of the SAIL referral. Please note that in addition to completing the referral form, the following supporting documentation is required:

- Current and all previous psychiatric/psychological assessments/evaluations
- Current hospitalization initial assessment/records, if applicable
- Copies of hospital and treatment discharge summaries
- Current outpatient provider assessments and case notes

We are here to help with this process. For questions and further assistance, please call 414.257.8095.



MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
COMMUNITY SERVICES BRANCH  
SERVICE ACCESS TO INDEPENDENT LIVING (SAIL)

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Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Alternate \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: M F Marital Status: \_\_\_\_\_

Diagnosis: Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Current service providers (Please include name, agency and phone number.)

Psychiatrist \_\_\_\_\_

Case Manager \_\_\_\_\_

Therapist \_\_\_\_\_

Other \_\_\_\_\_

SAIL Services Requested: Day Treatment Case Management- TCM  
Case Management –CSP CBRF (Group Home)

Insurance: Please include copy of card if applicable.

None T-18/T-19 Pending

T-18 (Medicare #) \_\_\_\_\_ T-19 (Medicaid #) \_\_\_\_\_

HMO (Name and #) \_\_\_\_\_

Private Insurance (Name and Group/Policy #) \_\_\_\_\_

Veteran's Benefits \_\_\_\_\_

Income: Amt/Mo: \_\_\_\_\_ SSI SSD Wages Pension Other \_\_\_\_\_

SSI/SSD Application Status: Pending Appeal Winged Victory Referral

Payee: \_\_\_\_\_ Relationship/Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Legal Status (Check all that apply): Voluntary Chapter 51 Chapter 55/880  
Parole/Probation Pending Criminal Charges

Please explain: (i.e., Stipulations, Commitment, Guardian) Attach copy of the order if applicable.

Referent's Interim Care Plan (Provider, Location, Frequency): \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

CSB USE ONLY- Medical Record Number: \_\_\_\_\_

**I. CLIENT PREFERENCES**

Please indicate the client's preferences for community services, in their own words.

\_\_\_\_\_  
\_\_\_\_\_

Please indicate any cultural needs of the client: \_\_\_\_\_

\_\_\_\_\_

**II. STRENGTHS**

Please list the client's strengths: \_\_\_\_\_

\_\_\_\_\_

**III. RISK FACTORS**

List problems that place client or others at risk based on past or current status. Include history of self-harm, vulnerability, violence, or criminal activity. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**IV. MENTAL HEALTH**

What is the client's understanding of his/her illness and motivation for treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Briefly describe history of inpatient and outpatient treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If presently hospitalized, where, & date of admission: \_\_\_\_\_

If presently hospitalized, anticipated date of discharge: \_\_\_\_\_

Current prescribed medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate one of the following:

Generally takes medications as prescribed

Often does not take medications as prescribed

Usually does not take medications as prescribed

**V. SUBSTANCE USE**

List history, types, frequency, treatment, and current substance use: \_\_\_\_\_

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**VI. TRAUMA**

Does the client have a history of physical, sexual, verbal and/or emotional abuse? Please describe.

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Describe any trauma treatment and its outcome.

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**VII. PHYSICAL/MEDICAL HEALTH**

Current providers (Please include name and phone number.)

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List conditions and/or disabilities: \_\_\_\_\_

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Describe any assistance the client requires to facilitate care (including adaptive devices).

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**VIII. COMMUNITY LIVING SKILLS**

Please indicate if problems arise in any of the following areas:

Hygiene	Housekeeping	Shopping
Dress	Money Management	Laundry
Cooking	Transportation	Reading

1. Does the client experience difficulty in day-to-day activities secondary to his/her mental illness?

If yes, please describe in detail. \_\_\_\_\_

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Client Name: \_\_\_\_\_

2. Indicate the client's daily activities, including involvement with employment, psychosocial clubs, partial hospitalization, DVR, etc.: \_\_\_\_\_

**IX. HOUSING**

Check the client's community living arrangement:

lives alone

lives with others Specify: \_\_\_\_\_

homeless and living:            in a shelter            on street

Housing is:    rented            owned

Cost:    \$\_\_\_\_\_/month    Subsidized?

If housing problems exist, please specify (include history of evictions, homelessness, etc.):

**X. SOCIAL SUPPORTS (Community and natural supports)**

	<u>Name</u>	<u>Relationship</u>	<u>Support Provided</u>
Yes	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
No	List support needs _____		
	_____		
	_____		

**XI. ADDITIONAL COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_