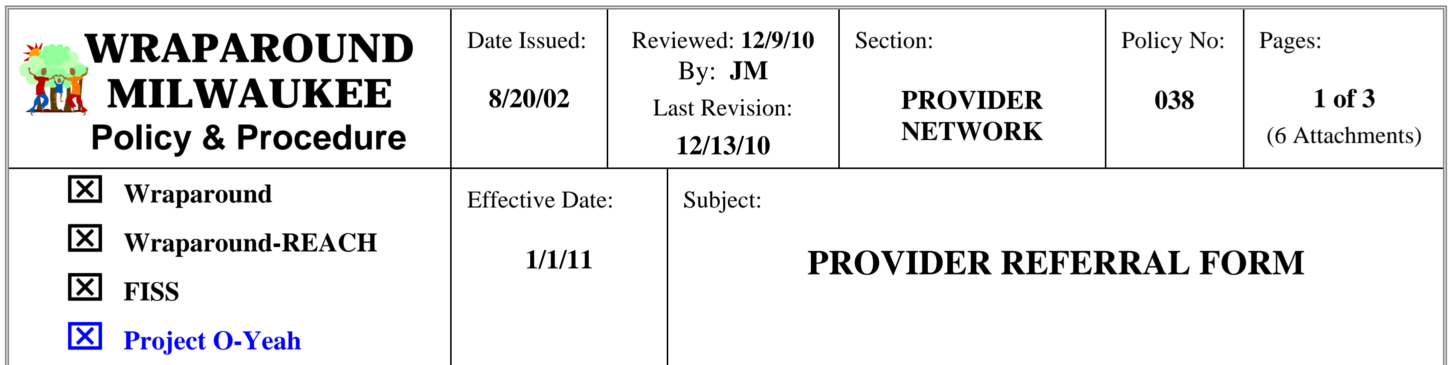

WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 8/20/02	Reviewed: 12/9/10 By: JM Last Revision: 12/13/10	Section: PROVIDER NETWORK	Policy No: 038	Pages: 1 of 3 (6 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 1/1/11	Subject: PROVIDER REFERRAL FORM			

I. POLICY

It is the policy of Wraparound Milwaukee and Family Intervention Support Services (FISS) that all paid Direct Service Providers receive a completed Provider Referral Form prior to providing services to a youth/family.

II. PROCEDURE

<u>Wraparound / REACH Only</u>

A. After a Child & Family Team decides that a service will be sought from a particular Service Provider, the Care Coordinator must get an AUTHORIZATION FOR RELEASE OF INFORMATION form (*see Attachment 1 for Wraparound, Attachment 2 for REACH*) signed by the parent/legal guardian before submitting/entering a PROVIDER REFERRAL FORM (*see Attachment 3*) and exchanging information with the prospective Provider. The Authorization for Release of Information form gives the Care Coordinator permission to speak with and share information with that Provider.

B. The Care Coordinator must then completely fill out the PROVIDER REFERRAL FORM and forward it to the prospective Provider. Telephone referrals alone are <u>not</u> sufficient.

1. If a service is being requested for the <u>identified enrollee</u>, the Care Coordinator may complete the Synthesis generated PROVIDER REFERRAL FORM (*see Attachment 4*) located under the Client Forms Tab in Synthesis. The Care Coordinator should use the service specific referral forms for: Treatment Foster Care, Transportation and Transportation-Americab (Taxi).
2. When requesting services for other family members (i.e., sibling, parents, caregivers, etc.), the Care Coordinator must complete a paper copy of the PROVIDER REFERRAL FORM (*see Attachment 3,* available on the Care Coordinator Frequently Used Forms Website.

C. Following receipt of a properly completed written referral for services, agencies providing services through the Wraparound Milwaukee Provider Network determine if they can adequately serve/meet the needs of the youth/family that has been referred to their agency for services. Unless otherwise identified in a Wraparound Milwaukee service specific policy or procedure (i.e., Crisis Stabilization/Supervision), Network agencies are to respond to the Wraparound Milwaukee Care Coordinator within 48 hours of receipt of a formal (written) referral for services and identify the time of the next available appointment for service.

The Wraparound Milwaukee Provider Network agency is to provide services within the time frames identified below or identify other qualified Network Providers that may be able to serve the youth and family. (*A list of Wraparound Milwaukee Provider Network agencies and individual direct service providers is available in the Synthesis Resource Guide – Wraparound Milwaukee's Information Management System. Agencies that do not already have access to Synthesis should contact the Synthesis Help Desk at (414) 257-7547.)*

Appointments for "urgent" care services should be available within 48 hours of receipt of a complete, written referral for the following services:

- AODA Assessment
- In-Home Lead
- Individual/Family Therapy – Office (including providers of High Risk Counseling and Therapy)
- Individual/Family Therapy – Licensed Psychologist – Office

First time appointments for routine non-urgent services are to be made available within 10 business days of receipt of a complete written referral for services for all individually provided services within the following Wraparound Milwaukee Provider Network service groups (*see Attached* ***"Service List by Program"*** *report for a list of services by Service Group)* including:

- AODA Services
- Child Care/Recreation Services
- Day Treatment Services
- Family/Parent Support Services
- In-Home Services
- Life Skills
- Outpatient Therapy Services
- Respite (Hourly; Foster Care)
- Youth Support Services

First time appointments for routine contact to be made within 60 calendar days of receipt of a referral for the following services:

- Assessment M.D.
- Med. Management/Nursing Services

For group services that are offered in a training "cycle" or "sequence" with designated points of entry in the cycle (*i.e., Anger Managemeent with a 6 week repeat cycle)*, the Care Coordinator/Case Manager is to be informed of the start date for the next available cycle for the identified service(s).

The youth/family may choose to waive the Wraparound Milwaukee service delivery requirement time frame if they prefer to wait for the next available appointment at a specific Wraparound Milwaukee Provider Network agency or with a specific Wraparound Milwaukee credentialed Direct Service Provider.

In the event that the youth and/or family elect to delay the onset of services, the Provider Network agency should notify the Care Coordinator/Case Manager, youth and family of any potential negative consequences that could result from delaying the start of services. The Care Coordinator/Case Manager should also inform the youth and family of any negative consequences they may be aware of that may impact on the youth and/or family (*i.e., compliance with court order, etc.)* when electing to delay the start of services.

D. If it is determined that the Provider can meet the identified youth/family needs, the Care Coordinator authorizes the service(s) in Synthesis so that the Provider can initiate services with the service recipient.

E. Care Coordinators are to introduce all new Providers to the service recipient/family at the first appointment.

FISS Only

A. Following the Initial Family Meeting (IFM), the FISS Services Manager will initiate direct telephone contact with a desired Wraparound Milwaukee Network Provider in order to establish the Provider's ability and availability to meet the specified service need of the youth/family within the designated time frame presented.

B. The FISS Services Manager then completes the FISS SERVICES PROVIDER REFERRAL FORM *(see Attachment 5)* to formally request services from the Provider, and to provide necessary youth/family information and the goal or purpose for the requested FISS Service. The Referral Form, including a copy of the signed FISS Services Consent for Release of Information Form *(see Attachment 6)*, is then faxed to the identified Services Provider.

C. Providers must have contact with the family within a 7-day period, if they are unavailable to attend the Initial Family Meeting with the FISS Services Manager.

ALL PROGRAMS (Wraparound, REACH, FISS and O-YEAH)

A. Providers can initiate services only upon receipt of a PROVIDER REFERRAL FORM. Services provided, prior to receiving the authorized Referral cannot be reimbursed.

B. There must be a PROVIDER REFERRAL FORM in the Wraparound Milwaukee Provider Network agency's Enrollee record for all youth/individuals served.

C. If a family, as a group, is receiving a service, then the PROVIDER REFERRAL FORM must be, at minimum, in the enrollee's/case head's file. If more than one file is being maintained on a family for that service, then a copy of the PROVIDER REFERRAL FORM must be present in all applicable files.

D. The Wraparound Milwaukee Provider Network agency must obtain a new PROVIDER REFERRAL FORM if the service changes, even though the new service is similar to the service already being provided. For example, a youth and family receiving In-Home psychotherapy services transfers to office based therapy services. The Wraparound Milwaukee Provider Network agency is required to have separate PROVIDER REFERRAL FORMS, one each for the In-Home service (Code 5160) and the Individual/Family Therapy Office Based (Code 5100).

E. Wraparound Milwaukee Provider Network agencies are responsible for communicating this policy with individual Direct Service Providers approved to provide services on behalf of their agency (employees and contract staff) through a Fee-for-Service Agreement with Wraparound Milwaukee.

Reviewed & Approved By:

Bruce Kamradt, Director

WRAPAROUND MILWAUKEE

AUTHORIZATION FOR RELEASE OF INFORMATION

PURPOSE OF DISCLOSURE:

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

____________________________________ (Youth's Name) ____________________ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the following agency/s that authorize enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

- **Milwaukee County Children's Court**
- **Medicaid/Title 19**
- **Bureau of Milwaukee Child Welfare**

In addition, I authorize release of information related to the above named youth to the following agencies identified below for the purpose of planning for and the delivery of ongoing mental health care, physical health care and education services.

PLACE AN "X" IN THE BOX NEXT TO AGENCY NAME TO AUTHORIZE INFORMATION RELEASE

	AGENCY NAME	INFORMATION TO BE RELEASED
☐	Families United of Milwaukee, Inc. *(Family Advocate)*	Demographic Information Only
☐	Wraparound Education Advocate ***Chris Shafer, Kay Frederick, Shirley Fishman***	Plan of Care, Diagnostic, Progress and School Reports
☐	Milwaukee Public Schools ________ *(Enter Name of School)*	Plan of Care, Diagnostic, Progress and School Reports
☐	Other School ________ *(Enter Name of School)*	Plan of Care, Diagnostic, Progress and School Reports
☐	Primary Care Physician ________ *(Enter Physician or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐	Dental Service Provider ________ *(Enter Dentist or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐	Psychiatrist ________ *(Enter Physician or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐	Other ________ *(Enter Agency or Individual Provider Name)*	Plan of Care, Diagnostic and Progress Reports

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying evaluation data obtained during my enrollment in Wraparound to be used for research to evaluate the effectiveness of the program. I understand that this research may be presented at conferences, universities and in publications. I understand that information collected for this research is part of the usual Wraparound evaluation procedures. I understand that my family's confidentiality will be protected. No information that is presented to the public will contain any identifying information such as name, address or telephone number.

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed**. I understand **that I may cancel this authorization at any time** (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled**.**

This authorization expires on the __________ day of ____________________, 20____.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

______________________________ ____________
Parent or Legal Guardian Signature — Date

______________________________ ____________
Youth Signature (*age 14 and older should sign)* — Date

______________________________ ____________
Witness Signature — Date

CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family and/or may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department***.***

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

WRAPAROUND MILWAUKEE – REACH

AUTHORIZATION FOR RELEASE OF INFORMATION

PURPOSE OF DISCLOSURE:

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

______________________________ (Youth's Name) ______________ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the State of Wisconsin/Title 19 Program that authorizes enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

In addition, I authorize release of information related to the above named youth to the following agencies identified below for the purpose of planning for and the delivery of ongoing mental health care, physical health care and education services.

PLACE AN "X" IN THE BOX NEXT TO AGENCY NAME TO AUTHORIZE INFORMATION RELEASE

AGENCY NAME	INFORMATION TO BE RELEASED
☐ Families United of Milwaukee, Inc. *(Family Advocate)*	Demographic Information Only
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☐ Other School ______ *(Enter Name of School)*	Plan of Care, Diagnostic, Progress and School Reports
☐ Primary Care Physician ______ *(Enter Physician or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐ Dental Service Provider ______ *(Enter Dentist or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐ Psychiatrist ______ *(Enter Physician or Clinic Name)*	Plan of Care, Diagnostic and Progress Reports
☐ Other ______ *(Enter Agency or Individual Provider Name)*	Plan of Care, Diagnostic and Progress Reports

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This authorization expires on the ______________ day of ______________________________, 20______.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

______________________________ ______________
Parent or Legal Guardian Signature Date

______________________________ ______________
Youth Signature (*age 14 and older should sign)* Date

______________________________ ______________
Witness Signature Date

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Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

WRAPAROUND MILWAUKEE

PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done with the Care Coordinator.

Referral Completion Date ____________________________

Referred by:

____ ____
Name of Care Coordinator Name of Care Coordination Agency

Phone (___)________________ Pager (____)________________ Cell Phone (____)__________________

Name of Provider/Agency being referred to:____

Address ____

City ____ State________________ Zip ________________

Name of Provider Contact Person __________________________________ Phone (____)______________

1. **Service being requested**:____ Service Code ______________
   Frequency / Days & Times being requested: ____
2. **Service being requested**:____ Service Code ____________________
   Frequency / Days & Times being requested: ____
3. **Service being requested**:____Service Code ____________________
   Frequency / Days & Times being requested: ____
4. **Service being requested**:____Service Code ____________________
   Frequency / Days & Times being requested: ____

Name of Client being Referred:_______________________________________ Phone (____)______________
Address ____
City____ State________________ Zip______________
Name of associated WM Enrollee (if different than client being referred) _____________________________________
Relationship of Referred Client to WM Enrollee (if not the same – i.e., mother, sibling, etc.)_____________________

Client Lives With:____ **Relationship:**_________________________

Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian ☐ Other ______________

Gender: ☐ Male ☐ Female **DOB**: ____________________ **SSN:** _________________________________

Special Accommodation Needs, if any *(i.e., physical and sensory disabilities, medical needs, limitations, etc):*

____

FAMILY/SCHOOL INFORMATION

Mother/Legal Guardian ____ Home Phone (____)_________________

Address ____ Work Phone (____)_________________

City____ State________________ Zip _________________

Father/Legal Guardian ____ Home Phone (____)__________________

Address ____ Work Phone (____)__________________

City____ State _______________ Zip __________________

Other Emergency Contact _______________________________________ Home Phone (____)________________

Address ____ Work Phone (____)_________________

City____ State_________________ Zip ________________

Relationship to Client _______________________________

Siblings/Children: (*Not required for transportation services if only transporting identified client*.)

1. _______________________________________ **DOB** ______________________

2. _______________________________________ **DOB** ______________________

3. _______________________________________ **DOB** ______________________

4. _______________________________________ **DOB** ______________________

School ____ ☐ Not Attending ☐ Not Enrolled ☐ N/A

Grade ______________ **Special Education:** ☐ Yes ☐ No

GENERAL INFORMATION

Diagnosis: *(Required only if referring to medical or mental health providers.)*

____

Currently on Medication? ☐ **Yes** ☐ **No** **If yes, what type?** ___________________________________

Strengths/Interests*:* (*Not required for transportation referrals.)*

____

____

____

Needs/Reason for Referral: (*Not required for transportation referrals.)*

____

____

____

Safety Concerns: ____

____

____

____

....

(For Provider Agency Use Only)

Date Referral was Received ______________________

Wraparound Milwaukee
Provider Referral Form

Name: **Enrollee, Sample**
DOB: 1/1/91 Ethnicity: Bi-racial
Gender: Female

Referral Date: 3/21/10
Care Coord: Tammy McShepard
Phone No(s): office 358-7952 / emergency pager 205-0577 / Weekend 333-6185.
Email: tmcshepard@altlig.com

Supervisor Name: Rob Bergeson
Phone No. 358-7960
Supv. Email: rbergeson@altlig.com

SAMPLE SYNTHESIS GENERATED REFERRAL FORM

Current Placement:

Date	*Type*	*Location*
3/1/05	Foster, Pre-adoptive	Foster Home

Contact Information

Youth	Sample Enrollee	9999 Any Street Milwaukee, WI 53201
Mother	Mary Enrollee	5858 S. 5th St. Milwaukee, WI 55555
Guardian	Mary Smith	No address listed
Father	Joe Father	2323 S.44th Street Milwaukee, WI 53223

School Information

School Name	*Grade*	*Special Education?*

Diagnoses:

Axis	*Description*
I	Schizophrenia, Disorganized Type
I	Mental Disorder NOS Due to General Medical Condition
I	Alcohol Related Disorder NOS

Axis	*Description*
III	
IV	
V	

Diagnosed By:
Diagnoses Date:

Current Medications

Type	*Used For*	*Dosage/Frequency*	*Prescribed By*	*Phone*
Albuteral inhaler	asthma	3 puffs - as needed	unknown	
Orthonovum	birth control	1 pill - daily	unknown	
Ritalin	hyperactivity	20mg - 2X a day	Dr. Chou	555-0000
testupdated	testupdated	testupdated - testupdated	testupdated	test
ritalin	hyperactivity	5mg - 2X daily	Dr. Smith	555-8989
Aspirin	headaches	1 pll - as needed		

Strengths/Interests

This youth like to play checkers and watch comics on TV. Enjoys things that he can do by himself. Draws a little - but doesn't like to talk about it.

Needs/Reason for Referral

Youth has very low self esteem. Sometimes talks about people being better off if he were dead.

Safety Concerns

Can become verbally agressive if he feels threatened and backed into a corner.

SAMPLE SYNTHESIS GENERATED REFERRAL FORM

Name of Provider/Agency Being Referred to:

ABC Counseling Service

Service Code Being Requested

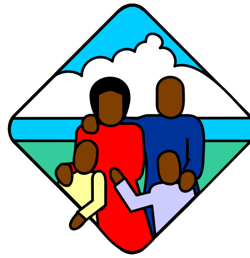
5100

Service(s) Being Requested

Individual/Family Therapy

Special Accommodation Needs, if any

None at this time. May do better is seen in the home, but would like to try being seen by the therapist at the clinic first.



FISS SERVICES

Behavioral Health Division

REFERRAL FORM FOR PROVIDERS OF SAFENOW

DATE:			
PROGRAM:	FISS		
REFERRED BY:		**AGENCY:**	St. Charles Youth & Family
		PHONE:	
PROVIDER:		**PHONE:**	
		FAX:	
INDIVIDUAL REFERRED:		**SOCIAL SECURITY #:**	
ADDRESS:			
TELEPHONE #:			
SEX:		**HERITAGE:**	
LIVES WITH:			

FAMILY INFORMATION

MOTHER'S NAME:		**HOME PHONE:**	
SS #:		**WORK PHONE:**	
ETHNICITY:		**ADDRESS:**	
FATHER'S NAME:		**HOME PHONE:**	
		WORK PHONE:	
		ADDRESS:	
CHILD(REN)/SIBLINGS:		**DOB:**	
		DOB:	
		DOB:	

		DOB:	
		DOB:	
		DOB:	
OTHER EMERGENCY CONTACT:		**TELEPHONE NUMBERS:**	

GENERAL INFORMATION

SCHOOL:	ENROLLED _______	NOT ENROLLED _______
GRADE:	SPECIAL ED: YES: _______ NO: _______	
RECREATIONAL ACTIVITIES/INTERESTS:		
CURRENTLY ON MEDICATION:	YES: _______ NO: ________	
IF YES, WHAT TYPE:		

Narrative describing relevant information/family dynamics/safety concerns:
This is a FISS case.
Physical problems/special needs/limitations:
Goals of Services:
➢
➢
➢
➢
➢

PLEASE INFORM SSM OF CASE ASSIGNMENT WITHIN 24 HOURS

Authorized Services:			
Service Recipient	*Intervention*	***Service Code***	*Unit/Description*

FISS SERVICES PROGRAM

CONSENT FOR RELEASE OF INFORMATION

CONSENT FOR RELEASE OF INFORMATION that is needed to plan and provide for the care, treatment and services of:

______________________________	______________________
Parent/Guardian	**Date of Birth**
Child's Name	**Date of Birth**
Child's Name	**Date of Birth**
Child's Name	**Date of Birth**

The following agencies:

- ☐ Milwaukee Public Schools or current School District______________________________
- ☐ Bureau of Milwaukee Child Welfare
- ☐ Milwaukee County Children's Court Center
- ☐ Wraparound Milwaukee / Mobile Urgent Treatment Team
- ☐ Family Advocate
- ☐ Title 19 or Medical Insurance Provider – List Name of Insurance Co. ______________________
- ☐ Other ____
  ____
  ____

have my permission to give/receive/share with Milwaukee County Behavioral Health Division and it's contract service coordination agencies:

____
(Name of Services Manager / Services Agency)

the following documents/information, which includes: diagnosis, prognosis and treatment of physical illness, mental health disorder, alcohol or drug abuse issues, educational issues/needs, legal issues/needs, social/recreational issues/needs, or other:

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of this Authorization – I understand that if I sign this Authorization, I will be provided with a copy of this Authorization.

Right to Refuse to Sign this Authorization – I understand that I am under no obligation to sign this form and that FISS Services Program may not condition treatment, payment, or enrollment of my decision to sign this Authorization.

Failure to Sign – I understand that failure to sign this Authorization may severely limit the treatment / service options available for my child or family.

Right to Withdraw this Authorization – I understand that I have the right to withdraw this Authorization at any time by providing a written statement to the FISS program (the statement must be dated and signed). I am aware that my withdrawal will not be effective until received by the FISS Services program and will not be effective regarding the uses and/or disclosures of my health information that the FISS Services program has made prior to receipt of my withdrawal statement.

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information.

HIV Test Results – I understand that my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this Authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

If not specified below, I understand that this Consent for Release of Information expires 12 months from the date it was signed. I also understand that I may cancel this Consent at any time (see above for Instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that such consent was cancelled.

This Consent expires on the _____________________ day of _______________________________, 20____________.

Parent's or Guardian's Signature	**Date**
Witness Signature	**Date**