WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 8/20/02	Reviewed: 9/27/12 By: WA Last Revision: 10/18/12	Section: PROVIDER NETWORK	Policy No: 038	Pages: 1 of 3 (5 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 1/1/13	Subject: **PROVIDER REFERRAL FORM**			

I. POLICY

It is the policy of Wraparound Milwaukee, REACH, Family Intervention Support Services (FISS) and O-YEAH that all Provider Agenices receive a completed Provider Referral Form prior to providing services to a youth/family.

II. PROCEDURE

Wraparound / REACH Only

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*) signed by the parent/legal guardian before submitting/entering a PROVIDER REFERRAL FORM (*see Attachment 2*) 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 calls alone to refer a client for services are not sufficient.

1. If a service is being requested for the identified enrollee, the Care Coordinator must complete the Synthesis generated PROVIDER REFERRAL FORM (*see Attachment 3*) located under the Client Forms Tab in Synthesis. The Care Coordinator must use the service specific referral forms for: Out-of-Home Care, Transportation and Transportation-Americab (Taxi) and O-YEAH referrals.
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 2)*, available on the Care Coordinator Frequently Used Forms Website.

C. Following receipt of a Provider Referral Form, 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 Provider Referral Form 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 Provider Referral Form 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 Provider Referral Form for all individually provided services within the following Wraparound Milwaukee Provider Network service groups (*see **"Service List by Program"** report in Synthesis 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 Provider Referral Form for the following services:

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

For group services that are offered in a "cycle" or "sequence" with designated points of entry in the cycle (*i.e., Anger Management 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 shall 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 shall 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 shall 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 4)* 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 5)*, 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 Provider Referral Form shall not 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

Bruce Kamradt, Director

WRAPAROUND MILWAUKEE / REACH

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

PURPOSE OF INFORMATION RELEASE/EXCHANGE:

Release / exchange of mental health (Enrollment notification and information, Plan of Care – including diagnosis/prognosis, and Progress Reports) AODA (Alcohol and Other Drug Addiction), physical health and school progress 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 the Mobile Urgent Treatment Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

Place your initials in the box next to the agency name to authorize information release/exchange.

	AGENCY NAME	ADDITIONAL INFO. TO BE RELEASED/EXCHANGED
☐	Insurance Carrier - Medicaid / Title 19	_____
☐	Insurance Carrier – Other _____ (Insurance Company Name)	_____
☐	Bureau of Milwaukee Child Welfare	_____
☐	Milwaukee County Children's Court	_____
☐	Wraparound Education Advocates Chris Shafer, Laverne Lunde, Shirley Fishman	_____
☐	Families United of Milwaukee, Inc. *(Family Advocacy Agency)* _____	
☐	Milwaukee Public Schools _____ (School Name)	_____
☐	Other Schools _____ (School Name)	_____
☐	Primary Care Physician _____ (Physician	_____
	_____ (Clinic Name /	_____
☐	Other-Name _____	_____
	Address: _____	_____

☐ Youth in Wraparound and REACH are also encouraged to participate in our **Wraparound Youth Council and Clubhouse** activities. By initialing here you authorize Youth Council representatives to contact your child directly regarding activities and events.

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying data obtained during my enrollment to be used for research to evaluate the effectiveness of the program. No information that is presented will contain any identifying personal information.

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation 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

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE 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. If my child is enrolled in Wraparound Milwaukee as part of a court order, I understand that failure to sign this form 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 released/exchanged 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

PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done <u>with</u> 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 Policy
Attachment 3

Wraparound Milwaukee
Provider Referral Form

Name: **Enrollee, Test**
DOB: 1/1/02 Ethnicity: Bi-racial
Gender: Female

SAMPLE SYNTHESIS GENERATED REFERRAL FORM

Referral Date: 3/21/10
Care Coord:
Phone No(s): NULL

Current Placement:

Date	*Type*	*Location*
8/17/10	Group Home	Servant Manor GH

Contact Information

Youth	Test Enrollee	Ann Smith 9999 Any Street Milwaukee, WI 53201
Mother	Mary Enrollee	5858 S. 5th St. Milwaukee, WI 55555
Father	Joe Father	2323 S.44th Street Milwaukee, WI 53223

School Information

School	*Grade*	*Phone*	*ContactPerson*	*IEPDate*	
Auer Avenue	1st	222	me	4/1/11	
				Spec Ed Types	CD
				Spec Ed Types	N/A
				Spec Ed Types	OHI

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.

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**