Revised 9.23.2021

Milwaukee County
Department of Health and Human Services
Disability Resource Center

DMCPS / CLTS / CCOP/ WRAP / CCS Referral for Adult LTC

To determine if a young adult may be eligible for long-term care services because she/he has a severe intellectual/developmental or physical disability, please complete this form below.

Please send form when:

- Young adult is a least 17.9 (assessment will occur approximately 2 months prior to 18th birth date)
- **Guardianship court date is established if young adult needs a guardian.**

DO NOT SEND REFERRAL if the plan is to extend CHIPS or Delinquency Order to age 21.

Customer Name: _____ Date of Birth: _____
MCI#_____ (if applicable)

Current Living Arrangement: Parent/Guardian ___Foster Care___ Group Home __ Institution ___
Placement Date: _____

Name of current residential facility or provider: _____
Contact person: _____ Phone Number: _____
Address: _____ City_____ Zip Code_____

Current School: _____ Type of Program: _____
Current Grade Level: _____ Name of Teacher: _____ Phone: _____

Name of Significant Others /Relatives (support or emergency contracts): Name: _____
Phone: _____Relation to client _____

Do you feel the young adult will require a guardian when she/he turns 18? Yes____ No____
Name of Proposed guardian: _____Phone_____

Open DMCPS Ongoing Case: Yes___ No___ CHIPs Order Expiration Date: _____
DMCPS Case Manager's Name: _____ Phone: _____
Agency Name: _____ Case manager's email address: _____

Open Wraparound Case: Yes___ No___ Delinquency Court Order: Yes No
Delinquency Order Expiration Date: _____
Wraparound Case Manager's Name: _____ Phone_____
Agency Name: _____ Case manager's email address: _____

Open CCS Case: Yes___ No___ Delinquency Court Order: Yes No
Delinquency Order Expiration Date: _____
CCS Case Manager's Name: _____ Phone_____
Agency Name: _____ Case manager's email address: _____

Open CLTS /CCOP: Yes___ No___
Service Coordinator Name: _____ Phone _____ Email: _____
Agency Name_____ Phone _____

Medical conditions/Diagnoses (if known)

Intellectual Disability Kidney Disease/Failure Learning Disability Multiple Sclerosis Neuropathy Paraplegia Quadriplegia Speech Impairment Mental Illness Other

Medical Documentation:

- **Medical Diagnosis**: medical documentation within 1yr, acceptable documents may include: Hospital or clinic discharge summary, Doctor's visit after-visit summary)
- **IQ Test Results:** full-scale IQ within the last 5 years
- **Psychological Evaluations:** we can accept evaluations older than 5yrs if the diagnosis will not go away (i.e. Intellectual and Developmental Disability, Cerebral Palsy, Autism, Schizophrenia, etc). If the diagnosis can go away/improve (i.e. depression, PTSD, Anxiety, etc.) we will need recent documentation with the last year.
- **Legal documentation:** Guardianship Court documents or date of hearing, POA, POH, copy of Supportive Decision-making agreement (
- **FISA Functional Screen-** copy of current functional screen

Assistance needed to complete ADLs/IADLs in the home

Type of Assistance	Independent	Assistance Needed	Describe Assistance Needed
BATHING			
DRESSING			
MOBILITY			
TOILETING			
TRANSFERRING			
MEAL PREP.			
MEDICATION			
MONEY MANAGEMENT			
SHC TASKS (Specify)			

SERVICES NEEDED

☐ PERSONAL CARE ☐ SUPPORTIVE HOME CARE ☐ CASE MANAGEMENT ☐ RESPITE
☐ TRANSPORTATION ☐ RESIDENTIAL ☐ ADAPTIVE AIDS ☐ RESPITE
☐OTHER:

Referring Agency Information:

DMCPS (DRC Liaison) Name: _____ Phone: _____Date:_____

Wraparound (DRC Liaison) Name: _____ Phone: _____Date:_____

CCS (DRC Liaison) Name: _____ Phone: _____Date:_____

Children's Supervisor Name _____ Phone:_____ Date:_____

Signature:_____ Date:_____

Email referral to: Hazel Miller-Option Counselor Supervisor hazel.miller@milwaukeecountywi.gov or call (414) 289-6302