**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: