

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 8/20/02	Reviewed: 10/7/09 By: JM Last Revision: 10/9/09	Section: PROVIDER NETWORK	Policy No: 038	Pages: 1 of 2 (6 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input checked="" type="checkbox"/> FISS	Effective Date: 1/1/10	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

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 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 not sufficient.
 1. If a service is being requested for the identified enrollee, the Care Coordinator may do 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 use the hard copy PROVIDER REFERRAL FORM (*see Attachment 3*)
- C. After receiving the Provider Referral Form information, the Direct Service Provider determines if they can adequately serve/meet the needs of the youth/family. 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 youth/family.
- D. Care Coordinators are expected to introduce all new Providers to the youth/family.

FISS Only

- A. Following the Initial Family Meeting (IFM), the FISS Services Manager will initiate direct telephone contact with a desired 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.

REMINDERS TO PROVIDERS (Wraparound, REACH and FISS)

1. Providers can initiate services only upon receipt of a Provider Referral Form. Services provided, prior to receiving the authorized Referral cannot be reimbursed.
2. There must be a Provider Referral Form in the Provider's Agency's client record for all youth/individuals being served.
3. 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.
4. A Provider must receive a Provider Referral Form whether the referral is made internally (i.e., a Care Coordinator at Agency ABC referring one of his/her client's to the In-Home program at Agency ABC) or externally (i.e., a Care Coordinator at Agency ABC is referring his/her client to the In-Home program at Agency XYZ).
5. The Provider must obtain a new referral 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 Provider 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).

Reviewed & Approved By: Bruce Kamradt
Bruce Kamradt, Director



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

Additionally, information as indicated below may be released to/received from the following:

SHARED DOCUMENTS/INFORMATION
 (Check those that apply.)

	Demographic Information Only	Plan of Care	Referral for Services	Other * (See Below)

Milwaukee Public Schools/other school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families United of Milwaukee, Inc. (Family Advocate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Primary Care Physician:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatrist:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Services Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Agency/Individual				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Agency/Individual				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Other Document/s: _____

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_____.

REDISCLASURE 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



AUTHORIZATION FOR RELEASE OF INFORMATION

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 (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.

Additionally, information as indicated below may be released to/received from the following:

SHARED DOCUMENTS/INFORMATION

(Check those that apply.)

Demographic Information Only	Plan of Care	Referral for Services	Other * (See Below)
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Milwaukee Public Schools/other school: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Families United of Milwaukee, Inc. (Family Advocate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Primary Care Physician: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Psychiatrist: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Dental Services Provider: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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*Other Document/s: _____

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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_____.

REDISCLASURE 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:

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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.

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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

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: _____

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(For Provider Agency Use Only)

Date Referral was Received _____

PROVIDER REFERRAL FORM

SYNTHESIS
ON-LINE
FORM

Referral Date: 7/1/05
Referred By: Aggie Hale, Wraparound Milwaukee
Phone Number(s):

Wraparound Milwaukee Enrollee Name: Client, Sample
DOB: 1/1/91 Ethnicity: Bi-Racial
Gender: Male

Current Placement:
Date Type Location
12/1/04 RCC Home Home - Newville
2/1/05 Home Parent

Contact Information

Youth Sample Client 1234 Any Street
Milwaukee, WI 53201

Mother Mary Client 5858 S. 5th Street
Milwaukee, WI 55555

Father Unknown No address listed

Siblings / Children (not required for transportation services if only transporting identified client)

Name Relationship DOB
No siblings / children listed

School Information

School Name Grade Special Education?

Diagnoses:

<i>Axis</i>	<i>Description</i>	<i>Axis</i>	<i>Description</i>
I (R/O)	Oppositional Defiant Disorder	III	Asthma
I (Primary)	Attention Deficit Dis., combined type	IV	Divorce of Parents
II	Communication Disorder NOS	V	45

Diagnosed By: Dr. Jones
Diagnoses Date: 5/1/2005

Current Medications

<u>Type</u>	<u>Used For</u>	<u>Dosage/Frequency</u>	<u>Prescribed By</u>	<u>Phone</u>
Ritalin	Hyperactivity	5 mg. - 2X Daily	Dr. Smith	555-8989
Albuteral Inhaler	Asthma	3 puffs - as needed	Unknown	
Orthonovum	Birth Control	1 pill - Daily	Unknown	

Safety Concerns

Safety concerns are...

Name of Provider/Agency Being Referred to:

Acme Clinic
555 S. 5th Street
Milwaukee, WI 55555



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:			
<i>Service Recipient</i>	Intervention	Service Code	<i>Unit/Description</i>

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.

REDISCLASURE 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