

**Eau Claire County Department of Human Services
Children's Long Term Services (CLTS) Referral Form**

Please return to Human Services Centralized Access

Email: HumanServices.Access@co.eau-claire.wi.us

Fax Number: 715-831-5658

Phone Number: 715-839-7118

Person completing form: _____

Phone Number: _____

Email: _____

Date of contact: _____

Child's Name: _____

Child's Date of Birth: _____

Child resides with: Parent Guardian Other

Parent(s) Name: _____

Parent's Address: _____

City: _____

ZIP: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Best Time to Contact: _____

**Guardian Name (if not
living with parent):** _____

Guardian's Address: _____

City: _____

ZIP: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Best Time to Contact: _____

**Court Ordered Guardianship
Documents on File:** Yes No

Child's Diagnoses: _____

**Child's has long-term functional impairments are expected to last 6 months or longer in
one or more of the following areas:**

Self-care Mobility Learning Communication Behaviors

Describe: _____

If the child has a clinical diagnosis of a mental health disability has the diagnosis or symptoms persisted for at least 6 months? Yes No

Is the mental health diagnosis expected to last for 1 year or longer? Yes No

Diagnosing Provider Name: _____

Medical Facility: _____

Symptoms Present:

Psychosis –serious mental illness with delusions, hallucinations, and/or lost contact with reality

Suicidality – Suicide attempt in the past 3 months or significant suicidal ideation or plan in the past month

- Violence – Life threatening acts
- Anorexia/Bulimia – Life threatening symptomatology
- No symptoms apply

Child's Current Services:

<input type="checkbox"/> Public Health Nurse: Name: _____ Agency: _____ <input type="checkbox"/> Home Health Agency: Name: _____ Agency: _____ <input type="checkbox"/> Birth to 3 Program: Name: _____ Agency: _____ <input type="checkbox"/> Counseling: Name: _____ Agency: _____ <input type="checkbox"/> Current School: _____ Contact Person: _____	<input type="checkbox"/> Human Services Social Worker: Name: _____ Agency: _____ <input type="checkbox"/> Foster Care/Treatment Foster Care: Name: _____ Agency: _____ <input type="checkbox"/> Substance Abuse Services: Name: _____ Agency: _____ <input type="checkbox"/> Behavior Health Services: Name: _____ Agency: _____
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- IEP
 Behavior Plan
 Speech
 OT
 PT

Other: _____

Economic Services:

<input type="checkbox"/> Badger Care <input type="checkbox"/> SSI <input type="checkbox"/> Private Insurance <input type="checkbox"/> Food Share	<input type="checkbox"/> Katie Beckett <input type="checkbox"/> Medicaid <input type="checkbox"/> WIC (< 5 years of age) <input type="checkbox"/> Child Care Assistance
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Health Related Services (If applicable):

Does child have needs that might require skilled nursing services (cancer, positioning, tube feedings, ventilator, etc.)? Yes No

How long have the health related services lasted? < 6 months
 6 – 12 months
 > 12 months

How long are skilled and health service needs expected to last? < 6 months
 6 – 12 months
 > 12 months

Detail of Child's Unmet Needs:

I am aware of this referral and give my consent to _____ to refer my child to the Eau Claire County Children's Long Term Support Program.

Signature of Individual Authorizing Referral	Date Signed
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