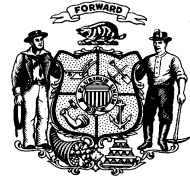




EAU CLAIRE COUNTY Coordinated Services Team



Eau Claire County
Department of Human Services
721 Oxford Avenue, Ste. R-1, P.O. Box 840
Eau Claire, WI 54702-0840
Centralized Access Phone: 715-839-7118
Email: HumanServices.Access@co.eau-claire.wi.us
Fax: 715-831-5856

Referral Form

Name of child (include middle initial): _____
Date of Birth: _____ Age: _____ SSN: (Optional) _____

Complete the following information if different from above:

Caregiver/Parent(s) Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
Referral Person: _____ Referral Date: _____
Phone Number: _____ FAX #: _____
Reason for Referral: _____

Are there any safety concerns for the family (violent behavior, unsafe conditions)?

Is the child at risk of out of home placement or hospitalization? If so, please explain.

Funding source (check): MA SSI Katie Beckett Private Insurance Parents
 Other (please describe) _____

- Please check all that apply:**
- Use of multiple direct services (e.g. mental health, special education, juvenile justice, child protective services, alcohol or other drug services)
 - Other interventions have not been successful over time, or persistent obstacles to service access and/or need for service coordination exists
 - At risk of out of home/institutional placement
 - Parents are willing to be involved in the CST process

List other significant people not in the home (please include age and relationship):

Service Provider Information

Does the child have a Mental Health diagnosis?

Mental Health Provider: _____

Contact Person: _____ Phone Number: _____

Fax #: _____

Describe Involvement: _____

*Is the child involved with the Juvenile Justice system,
Child Protective Services (CPS), or Alcohol/Other Drug Abuse (AODA) services?*

If **yes**, please complete the provider information below.

If **no**, please continue with "Educational Provider" information.

Juvenile Justice, CPS, or AODA Service Provider: _____

Contact Person: _____ Phone Number: _____

FAX #: _____

Describe Involvement: _____

Educational Provider:

Special Education? Yes No

Contact Person: _____ Phone Number: _____

FAX #: _____

Describe Involvement: _____

Other Agency/Provider: _____ Phone Number: _____

Describe Involvement: _____

Please describe the concerns you have about this child and/or family

Behavior: _____

Emotional state: _____

Physical disabilities: _____

Other: _____

Consent for Referral and Participation

I give my consent to _____ to refer my child and family members as identified to the Eau Claire County, Coordinated Services Team (CST). I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in the CST, it will be necessary for service providers to routinely review and share information.

_____ Date _____
Signature of Individual Authorizing Referral

_____ Date _____
Second Authorization/Witness Signature