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| Division of Behavioral Health  Interim Director - Astra Iheukumere  Division Administrator – Todd Campbell  1202 Northport Drive, Madison, Wisconsin 53704  PHONE: (608) 242-6200 FAX: (608) 283-1564 |

#### Referral for Dane County Youth Connect Program

**Dane County Department of Human Services-Behavioral Health Division**

Youth Crisis Stabilization Services Face Sheet

Submit with Referral to: [YouthConnect@countyofdane.com](mailto:YouthConnect@countyofdane.com)

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| Date: | | Click or tap to enter a date. | | | | | | | | | | | | | | | | | |
| Client Legal Name: | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | Preferred Name: | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | |
| SSN: | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | DOB: | | | | | | | Click or tap to enter a date. | | | | | | | | | | | | | | | | | | | | Gender Identity: | | | | | Choose an item. | | |
| Address: | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | | Click or tap here to enter text. | | | | | |
| Parent/Guardian Name: | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | | Click or tap here to enter text. | | | | | |
| Address (if different): | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Email: | | | | | | Click or tap here to enter text. | | | | | |
| Person Completing Referral: | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | Contact Information: | | | | | | | | Click or tap here to enter text. | | | | | | |
| Other Sources of Information: | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| Insurance: | | | | None | | | | | | | | | Medicaid/BadgerCare | | | | | | | | | | | | | | | | | | | | | | Private/HMO | | | | | | | | | | | | | | | | | | |
| Policy/Subscriber Number #: | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current School: | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | IEP | | | | 504 | | | |
| Primary Contact: | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | Phone/Email: | | | | | | | | | | Click or tap here to enter text. | | | | | |
| Is Youth Currently Hospitalized: | | | | | | | | | | | | | | | | | Yes | | | | | | No | | | | | | | | Admission Date: | | | | | | | | | | | | Click or tap to enter a date. | | | | | | | | | | |
| Pending Discharge Date:  Click or tap to enter a date. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hospital Name:  Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |
| Social Worker Name / Contact Information: | | | | | | | | | | | | | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Legal systems or any mandated services (Check all that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CPS | | Chapter 51 | | | | | | | | | | Treatment/Diversion | | | | | | | | | | | | | | | | | | | | | N/A | | | | | | | | |
| Social Worker Name / Contact Information: | | | | | | | | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Immediate Supports Needed/Identified (by youth/family):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Psychiatry | | | | | | | | | Psychological Evaluation | | | | | | | |
| Crisis Planning/Intervention | | | | | | | | | | | | | | | | Family/Parent Peer Support | | | | | | | | | | | | | | | | | | | | | | | | MH System Navigation/Coordination | | | | | | | | | | | | | |
| Therapist | | | | | Discharge Planning | | | | | | | | | | | | | | | Respite | | | | | | | | | | | | Other | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | |
| Current Natural & Community Supports: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Agency: | | | | | | | Click or tap here to enter text. | | | | | | | Relationship: | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | Click or tap here to enter text. | |
| Name/Agency: | | | | | | | Click or tap here to enter text. | | | | | | | Relationship: | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | Click or tap here to enter text. | |
| Name/Agency: | | | | | | | Click or tap here to enter text. | | | | | | | Relationship: | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | Click or tap here to enter text. | |
| **Treatment Providers** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Care | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Psychiatrist/Prescriber | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| Is the youth currently working with a therapist? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | |  | | | | | | | |
| Name |  | | | | | | | | | | | | | | | | | | | | | | | Contact Info: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Is the youth currently enrolled in: | | | | | | | | | | | | | | | | | | CCS:  Yes | | | | | | | | | | | No | | | | | | | CLTS:  Yes | | | | | | | | No | | | | | Other:Click or tap here to enter text. | | | | |
| If Yes, Name & Contact Info: | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the applicant applied for any other support services/programs with pending eligibility determination? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | No | | | | | | | | If so, specify: | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral Status: | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Mental Health and/or Substance Use Concerns** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnoses | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosing Doctor/Medical Professional | | | | | | | | | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Info: | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | If none is help needed to seek a diagnosis? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | No |
| Please provide the following information, including dates: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ER visits, psychiatric evaluation, or psychiatric hospitalizations in past 6 months: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dates: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | Reason: | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dates: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | Reason: | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jail or Detention Stays:  Yes | | | | | | | | | | | | | | | No | | | | | | Date/Type: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recent Contact with law enforcement:  Yes | | | | | | | | | | | | | | | | | | | | | | | | | | No | | | | | | | | Dates/Reason: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |
| In the past 12 months has the youth exhibited any of the following? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychosis: Serious mental illness with delusions, hallucinations, and / or lost contact with reality | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Suicidality: Suicide attempt in past 12 months or significant suicidal ideation or plan in past month | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Violence: Life threatening acts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please describe: | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Youth or Family Stressors/Needs: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent referral for MH/SU Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Economic | | | | | | | | | | | | | | | | | | | |
| Language/Cultural barriers to treatment services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Housing | | | | | | | | | | | | | | | | | | | |
| Benefits counseling/application assistance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Transportation | | | | | | | | | | | | | | | | | | | |
| School Supports/Advocacy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other relevant information: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Language: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Eligibility Determination:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review Date: Click or tap to enter a date. | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | No | | | | | | | YCS Initials: Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Follow up Notes: | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |