Current Status: *Active* **PolicyStat ID:** *10758073*

Date Issued: *8/20/2002*
Effective: *11/29/2021*
Last Approved Date: *11/29/2021*
Last Revised Date: *11/29/2021*
Next Review: *6/30/2023*
Owner: *Dana James: Integrated Services Manager- Quality Assurance*
Policy Area: *Wraparound (Wrap, REACH, youth CCS)-Prov. Netwk.*
References:

#038- Provider Referral Form

I. POLICY

It is the policy of Children's Community Mental Health Services and Wraparound Milwaukee/Family Intervention Support Services (FISS), that all Provider Agencies receive a completed Provider Referral Form prior to providing services to a youth/family.

NOTE: This policy utilizes the term "Care Coordinator", which also applies to FISS Case Managers, Wraparound/REACH Care Coordinators and CCS Care Coordinators. It also uses the terms "Child and Family Team" - which applies to any group of people that may be working with a youth/family or young adult. The term "Youth" is used in this policy and applies to the enrollee in the program, whether a child, adolescent, or young adult.

II. PROCEDURE

Wraparound/REACH/CCS Programs Only

A. After a Child & Family Team decides that a service will be sought and before a PROVIDER REFERRAL FORM (*see Attachment 1*) is entered and sent to a Provider, the Care Coordinator will review the Resource Guide (see the Children's Community Mental Health Services and Wraparound Milwaukee website: http://wraparoundmke.com/) with the youth/family to allow the them to have the opportunity to establish criteria that best meets their needs and preferences and to identify Providers that they would like to work with.

B. Before any exchange of information occurs, the Care Coordinator must get an AUTHORIZATION FOR RELEASE OF INFORMATION form (*see Confideniality/Exchange of Information Policy #009*) signed by the parent/legal guardian, the youth if aged 14 and above, or young adult if over 18 and is their own guardian. The Authorization for Release of Information Form gives the Care Coordinator permission to speak with and share information with that Provider.

C. Within 2 business days of meeting with the family to review the Resource Guide, the Care Coordinator must then completely fill out the PROVIDER REFERRAL FORM and forward it to the prospective Provider(s) which the youth and family have identified. Telephone calls alone to refer a client for services are **not** sufficient.

   1. The Care Coordinator must submit a PROVIDER REFERRAL FORM for each agency/organization

providing services to the enrollee. Referrals must be service specific and time relevant.

a. if a new referral for the same service type needs to be sent more than 60 days after the previous referral was sent, a new referral form will need to be completed in Synthesis.

2. If a service is being requested for the **identified enrollee**, the Care Coordinator must complete the Synthesis generated PROVIDER REFERRAL FORM (*see Attachment 1*) located under the Client Forms Tab in Synthesis. The Care Coordinator must use the service specific referral forms for Out-of-Home Care and 1:1 Staffing or Exceptional Rate request.

3. For Wraparound and REACH programs only: Services can be requested for other family members through the Children's Community Mental Health and Wraparound Milwaukee Provider network, as long as options available through other forms of insurance and community resources have been explored first or the desired service is only available in our network (i.e. Parent Coach).

a. When requesting services for other family members (i.e., sibling, parents, caregivers, etc.), the Care Coordinator must complete a PROVIDER REFERRAL FORM (*see Attachment 1)* located under the enrollee's Client Forms Tab in Synthesis for. The Care Coordinator must identify who the service is for on the Provider Referral Form. The Care Coordinator must also get an AUTHORIZATION FOR RELEASE OF INFORMATION form signed by the family member that will be receiving the services. If the sibling is below the age of 14, the parent/legal guardian would sign. If the sibling is aged 14 and above, they and their parent/legal guardian both will need to sign the consent form. If they are 18 years old or older, and their own guardian, they would sign for themselves.

b. If the requested service is for a crisis stabilizer for a family member, CC's must follow the outlined process in Policy #036- Crisis Stabilization/Supervision for review and determination of need.

D. Following receipt of a Provider Referral Form, agencies providing services through the Children's Community Mental Health Services and Wraparound Milwaukee Provider Network determine if they can adequately serve/meet the needs of the youth/family that has been referred to their agency for services. Unless otherwise identified in a Children's Community Mental Health Services and Wraparound Milwaukee service specific policy or procedure (i.e., Crisis Stabilization/Supervision), Network agencies are to respond to the Care Coordinator within 2 business days of receipt of a Provider Referral Form and identify the time of the next available appointment for service.

The Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency is to provide services within the time frames identified below or identify other qualified Network Providers that may be able to serve the youth/family/young adult. (*A list of In-Network agencies and individual direct service providers is available in the Synthesis Resource Guide – Children's Community Mental Health Services and Wraparound Milwaukee's Information Management System.*

Appointments for "urgent" care services should be available within 2 business days of receipt of a Provider Referral Form for the following services:

- AODA Assessment
- In-Home Lead
- Individual/Family Therapy – Office (including providers of High-Risk Counseling and Therapy)
- Individual/Family Therapy – Licensed Psychologist – Office

- Psychotherapy

First time appointments for routine non-urgent services are to be made available within 30 business days of receipt of a Provider Referral Form for all individually provided services within the following Children's Community Mental Health Services and Wraparound Milwaukee Provider Network service groups (*see **"Service List by Program"** report in Synthesis for a list of services by Service Group)* including:

- AODA Services
- Child Care/Recreation Services
- Day Treatment Services
- Family/Parent Support Services
- In-Home Services
- Life Skills
- Outpatient Therapy Services
- Respite (Hourly; Foster Care)
- Youth Support Services
- Wellness Management and Recovery/Recovery Support
- Employment Related Skill Training
- Individual Skill Development Enhancement

First time appointments for routine contact to be made within 90 calendar days of receipt of a Provider Referral Form for the following services:

- Assessment M.D.
- Medication Management/Nursing Services

For group services that are offered in a "cycle" or "sequence" with designated points of entry in the cycle (*i.e., Anger Management with a 6 week repeat cycle)*, the Care Coordinator is to be informed of the start date for the next available cycle for the identified service(s).

The youth/family may choose to waive the Children's Community Mental Health Services and Wraparound Milwaukee service delivery requirement time frame if they prefer to wait for the next available appointment at a specific Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency or with a specific Direct Service Provider.

In the event that the youth and/or family elect to delay the onset of services, the Provider Network agency shall notify the Care Coordinator, youth/family of any potential negative consequences that could result from delaying the start of services. The Care Coordinator shall also inform the youth and/or family of any negative consequences they may be aware of that may impact on the youth and/or family (*i.e., compliance with court order, etc.)* when electing to delay the start of services.

E. 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 Service Recipient.

F. Care Coordinators must introduce all new Providers to the service recipient/family at the first appointment.

This introduction should be outside of a Team/POC Meeting.

FISS Only

A. Following the Initial Family Meeting (IFM), the FISS Case Manager will initiate direct telephone contact with a desired Children's Community Mental Health Services and Wraparound Milwaukee 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 Case Manager then completes the PROVIDER REFERRAL FORM *(see Attachment 1)* 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 Consent for Release of Information Form *(see Attachment 2)*, is then faxed to the identified Service 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 Case Manager.

ALL PROGRAMS

A. Providers can initiate services only upon receipt of a PROVIDER REFERRAL FORM. Services provided, prior to receiving the authorized Provider Referral Form shall not be reimbursed.

B. There **must** be a PROVIDER REFERRAL FORM in the Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency's Enrollee record for all youth/individuals served.

C. 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.

D. The Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency must obtain a new PROVIDER REFERRAL FORM 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 Therapy services transfers to office-based therapy services. The Provider Agency 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).

E. Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agencies are responsible for communicating this policy with individual Direct Service Providers approved to provide services on behalf of their agency (employees and contract staff) through the Fee-for-Service Agreement with Children's Community Mental Health Services and Wraparound Milwaukee.

Attachments

2: FISS Services Consent for Release of Information Form
1: Provider Referral Form

Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	11/29/2021
	Brian McBride: ExDir2 – Program Administrator	11/29/2021
	Dana James: Integrated Services Manager- Quality Assurance	11/29/2021
	Dana James: Integrated Services Manager- Quality Assurance	11/29/2021

Wraparound Milwaukee Provider Referral Policy Attachment 1

Wraparound Milwaukee Provider Referral Form

Sample Synthesis Referral Form

Name: **Enrollee, Test**
DOB: 1/1/02 Ethnicity: Bi-racial
Gender: Female

Referral Date: 3/21/10
Care Coord:
Phone No(s): NULL

Current Placement:

Date	*Type*	*Location*

Contact Information

Youth	Test Enrollee	Ann Smith 9999 Any Street Milwaukee, WI 53201
Mother	Mary Enrollee	5858 S. 5th St. Milwaukee, WI 55555
Father	Joe Father	2323 S.44th Street Milwaukee, WI 53223

School Information

School	*Grade*	*Phone*	*ContactPerson*	*IEPDate*	
Auer Avenue	1st	222	me	4/1/11	
				Spec Ed Types	CD
				Spec Ed Types	N/A
				Spec Ed Types	OHI
Baraboo High School					
Bay View Middle/High School					
Bay View Middle/High School					
Bay View Middle/High School	12th				

Strengths/Interests

This youth like to play checkers and watch comics on TV. Enjoys things that he can do by himself. Draws a little - but doesn't like to talk about it.

Needs/Reason for Referral

Youth has very low self esteem. Sometimes talks about people being better off if he were dead.

Benchmarks / Desired Outcomes

Youth will be able to identify three things that he likes about himself whenever he is feeling upset.

Describe Any Safety Concerns
Can become verbally agressive if he feels threatened and backed into a corner.

Name of Provider/Agency Being Referred to:
ABC Counseling Service

Name of Agency Being Referred to
0

NON-NETWORK Vendors only: Name of Vendor

Service Code Being Requested
5100

Service Code being Requestedd
5100

Service(s) Being Requested
Individual/Family Therapy

Initial family contact needed by (date)
3/24/10

Initial appointment needed by (date)
4/1/10

Special Accommodation Needs, if any
None at this time. May do better is seen in the home, but would like to try being seen by the therapist at the clinic first.

FAMILY INTERVENTION SUPPORT & SERVICES (FISS) PROGRAM

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

PURPOSE OF INFORMATION RELEASE/EXCHANGE: Release/exchange of mental health (Enrollment notification and information, Plan of Care – including diagnosis/prognosis, and Progress Reports/Notes), AODA (Alcohol and Other Drug Addiction), physical health, billing information and school progress information that will be used to plan and provide for the care, treatment and services for:

Enrollee's Name:_____ **Date of Birth:**_____

I authorize Children's Community Mental Health Services and Wraparound Milwaukee, its sub-contracted FISS service agency, and the Milwaukee County Mobile Crisis Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

Place your initials in the box next to the agency name to authorize information release/exchange

	AGENCY NAME	ADDITIONAL INFO TO BE RELEASED/ EXCHANGED
	Insurance Carrier - Medicaid / Title 19 / Third Party Payer	
	Other Insurance Carrier Name**:**	
	Milwaukee County Behavioral Health Division/Programs	
	Division of Milwaukee Child Protective Services (DMCPS)	
	Youth and Family Justice Center/ Department of Youth & Family Services	
	Wisconsin State Public Defenders Office	
	Milwaukee County District Attorney's Office	
	Children's Community Mental Health Services and Wraparound Milwaukee Care Coordinator and their affiliated agency	
	Milwaukee County Children's Mobile Crisis Team	
	Milwaukee Public School District/ School Name:	
	Other School Name:	
	Primary Care Physician's Name: _____ Clinic Name/Address:	
	Other Name/Address:	

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying data obtained during my or my child's enrollment to be used for research to evaluate the effectiveness of the program. No information that is presented will contain any identifying personal information**.**

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation 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_____.

REDISCLOSURE 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/Legal Guardian's signature Date Enrollee's Signature (age 14 and older must sign) Date

_____ _____

Witness signature Date

CLIENT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION:

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.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment/service options available for me, my child or family. If I/my child am/is enrolled in Wraparound Milwaukee as part of a court order, I understand that failure to sign this form may result in a request to the courts to modify the court order that allows for the removal of Wraparound Milwaukee from the court order.

Right to Refuse to Sign This Consent/Acknowledgement Form - I understand that I am under no obligation to sign this form and that Children's Community Mental Health Services and Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

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 the Quality Assurance Department (414-257-7595).

HIV Test Results - I understand enrollee'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.

Right to Withdraw This Consent - I understand that I have the right to withdraw consent for any of the items identified on this Consent at any time by providing a written statement of withdrawal to the Quality Assurance Department. (The written statement must identify what Consent is being withdrawn, be dated and signed.) I am aware that my withdrawal will not be effective until received by Children's Community Mental Health Services and Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that was made prior to receipt of my withdrawal statement.

Submit your written request for withdrawal to:

Quality Assurance Manager
Children's Community Mental Health Services and Wraparound Milwaukee
9455 Watertown Plank Road
Milwaukee, WI 53226