Montgomery County
Collaboration Council
FOR CHILDREN, YOUTH AND FAMILIES
A LOCAL MANAGEMENT BOARD

# CHILDREN WITH INTENSIVE NEEDS (CWIN) REFERRAL FORM

**Children and families must reside in Montgomery County in order to receive LAM services.**

**Please fill in all questions.**

Date of referral _____ Child's Name _____ _____Gender ☐M ☐F

DOB _____Age _____Child's race & ethnicity_____

Child's current living situation (i.e.parents, hospital, foster care, etc)_____

Name of school _____ Current attendance status? _____

Grade _____ Is he/she in Special Education? ☐ Yes ☐No

What is his/hers present education environment (check one) ☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H ☐I

What is the educational Code? _____

Are key school staff (i.e. guidance counselor, PW, psychologist) involved with this child/family? ☐ Yes ☐ No

Referral source name & agency _____Zipcode_____

Relationship to child _____ Phone (w) _____ (cell) _____Email_____

Parent/Guardian _____ Phone (h) _____ (cell) _____ (w) _____

Address of family_____Zipcode_____

Parent/guardian race & ethnicity_____Language(s)_____

What is the child's insurance? □ MA #_ _____ ☐ Private ☐None ☐ Care for Kids (MCHP)

Details about child's behaviors and needs, and types of services requested (i.e. parenting, mentoring, out of home, etc.).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has the child had a psychiatric hospitalization? □ Yes □ No □ Unknown How many times?_____

Where?_____ Dates/time frames hospitalized _____

Reason (ie. suicidal, aggression)_____

Name of current therapist & agency_____

Phone (w) _____ (cell) _____ How long with this therapist? _____

Name of current psychiatrist & agency _____

Phone (w) _____ (cell) _____ How long with this psychiatrist? _____

Mental Health diagnosis _____

Is the child taking any psychiatric medication? _____ Medication/reason_____

Any prior therapy or medication tried in the past?_____

Does the child have any major physical issues? _____

Is/was the child involved in any agency/system? □ DJS □Child Welfare □ MCPS □ Other □ Unknown

Agency contact person_____ Phone (w) _____ (cell) _____

Is parent/guardian definitely interested in intensive in-home services from Wraparound, if eligible? □Yes □ No

Does caregiver have needs that interfere with caring for child (i.e. Mental Health, physical, substance use-related, finances)? _____

What are the caregiver's strengths (i.e. resources, involvement, knowledge, housing stability, keeps appointments)?

_____

Do the caregiver(s) and the child get along? _____

Please list 3 strengths that the child has: _____

_____

Do you think the child is 'at risk' of needing an Out-Of-Home placement? Why? _____

_____

Has a ***licensed clinician*** (therapist, psychiatrist ) assessed the child as being 'at risk' of a Residential Treatment Center (RTC) placement?❋ ▫ Yes ▫ No

❋Completion of a Clinical Recommendation Form may be requested with this application if child is at risk of RTC.

Any additional information that, would be helpful for us to know?

_____

_____

_____

_____

_____

_____

PLEASE SEND COMPLETED FORM TO ATTN: PATTY BROWN, LAM ASSOCIATE

FAX: 301-610-0148

PHONE: 301-354-4905

EMAIL: Patricia.brown@collaborationcouncil.org