Sound Wraparound with Intensive Services (WISe) Referral Form

Thank you for your interest in Sound's WISe wraparound program.

What is WISe Wraparound?

WISe is a specific service program that provides a variety of intensive behavioral health services to high-needs youth and their parents/caregivers. In addition to intensive mental health services, the service package includes building a supportive team around the family to help coordinate services. Team members often include other youth providers such as school, juvenile justice, intellectual and developmental disabilities, child welfare and other professional and natural supports whom develop a coordinated plan to address needed supports for the youth and family and natural supports from the family's network. The goal of WISe is to help youth stabilize their symptoms and overcome barriers so that they can be successful in their homes, schools and communities.

Eligibility:
Youth must qualify for this intensive level of services
Have current Medicaid
Children/youth up to 21 years of age
Youth and caregivers need to agree to actively participate in services on a weekly basis.

- Upon entering WISe Wraparound, you will be assigned a WISe therapist, a Family Care Coordinator, and a Parent/Youth partner.
- The majority of our meetings will take place in the community; Schools, community centers, your home etc.
- Your team will work in collaboration with all systems that are currently involved with your child such as school/IEP, DCYF/CPS, community members and natural supports.

What to expect during the referral process

Our WISe referral Coordinator will contact the referent/or youth and family in order to gather additional information to determine eligibility based on the Child and Adolescent Needs and Strengths (CANS) screening tool. If you have further questions please call our referral Coordinator at 206 451 9544; or use the WISe Admissions email: wiseadmissions@sound.health

Referent Information---- Date of referral:					
Referring Person		**Phone**		**Agency Name**	
Relationship to Youth		**Email**		**Address**	

Client Information							
Youth's Name		**DOB**		**Age**		**Gender Pronoun**	
Ethnicity		**Primary Language**		**Interpreter Needed**	☐ **Yes** ☐ **No**		
Phone # 1	Please check one: Home ☐ Work ☐ Cell ☐		**Phone #2**	Please Check one: Home ☐ Work ☐ Cell ☐			
Address	**Street Address:** **City:** **State:** **Zip:**						
Is the youth eligible for Medicaid? (Check one)	☐ **Yes** ☐ **No**		**Provider One #:**				

Parent/Guardian Information					
Name		**Relationship**			
Primary Language		**Interpreter Needed**	☐ **Yes** ☐ **No**		
Phone # 1	Please check one: ☐ Home ☐ Work ☐ cell	**Phone # 2**	Please check one ☐ Home ☐ Work ☐ Cell		
Email			I give permission to be contacted by email ☐ Yes ☐ No		
Address	**Street Address:** **City:** **State :** **Zip:**				

Educational Information				
School Name		**Home School District**		**Preferred Contact:** **Phone number:**
IEP ☐ 504 ☐	**Current Grade**	**Youth is currently (check one)**		☐ Enrolled ☐ Suspended ☐ Expelled

Household Members

Siblings, Foster Children, relatives, non-related person

Name	Age	Relationship	Name	Age	Relationship

Collaborative/system partners

(N/A if not applicable)

Current Involvement	Contact Person	Agency	Phone number
Sound Clinician		Sound	
Substance Use clinician			
Special Education			
DCYF/CPS			
Juvenile Justice			
DDA			

Family Strengths (Include family traditions, activities you enjoy doing together, skills, talents etc)	Reason for referral request (current hospitalizations, behaviors, self-harm, suicidal ideation etc)

Submit