WINGS Referral Form

Please complete this form to the best of your ability. We understand you many not have accesses to all information we are requesting, along with any available chemical health assessment, Mental Health assessments educations or IEP information along with this application. Please FAX to 320-593-0442 or email to Info@WINGSATS.COM

Clients name:_____Date of Birth:_____Contact Info (phone):_____

Current address:_____City/State/ZIP:_____

Social Security # (only needs last 4 digits)_____

Guardian #1 Name:_____ Contact Info (phone):_____Email:_____

Current address:_____City/State/ZIP:_____

Physical Custody:_____YES /_____NO Legal Custody:_____YES /_____NO

Guardian #2 Name:_____Contact Info (phone):_____ Email:_____

Current address:_____City/State/ZIP:_____
(if second guardian lives separate of first)

Physical Custody:_____YES /_____NO Legal Custody:____YES /____NO

Referring Agency:_____Date:_____

Agency contact number: _____

Contact Person #1 with Agency: _____Email:_____

Contact Person #2 with Agency:_____Email:_____

How will this client be Funded: Private Insurance / PMAP / CCDTF (please circle)

Insurance Company:_____Policy ID:_____Group #:_____

Medical Assistance #: _____

Involved External Care Team Members:

Probation Officer: Name_____Phone #:_____Email:_____

Social Worker: Name:_____Phone #:_____ Email:_____

Rule 25/CCDTF Funding Contact: Name:_____Phone#:_____

Email Address:_____

Misc: Name:_____Phone # :_____Email:_____

Need for Residential service as soon as available?_____YES /_____NO
or
Review as a Backup plan for a lower level of care:_____YES /_____NO

Is referred client an IV user:_____YES /____NO Is referred Client Pregnant?_____YES /_____NO

Is referred client willing to participate in a phone screening?_____YES /_____NO /_____Uncertain

History of referred client's participation in lower levels of care

☐ YES: Please provide details (Completion status date of service termination)

_____

_____

☐ NO: Rational for forgoing lower level of care prior to referral to residential

_____

_____

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Referred client history of physical aggression?

☐ YES: Please provide details

_____

_____

☐ NO

Medical needs carrying the potential to create barrier to residential treatment (physical limitations to participation in recreational activities, phobias or unwillingness to consent to blood draw for admission physical, requirement of opioid pain relievers for current or recent injury, misc. other)

☐ YES: Please provide details

_____

_____

☐ NO

Personal belief carrying the potential to create barriers to residential treatment? (Animate resistance to residential treatment participation, unwillingness to explore medication options as needed, guardian unwillingness to cooperate or engage in support of client's residential treatment)

☐ Yes: Please provide details

_____

_____

☐ NO

Miscellaneous/other potential barriers to residential treatment? (Inactive or transitioning medical insurance, primary guardian residing out of the state of MN which causes barriers to funding of educational services provided by Meeker and Wright Special Education Cooperative -our educational provider)

☐ Yes: Please provide details

_____

_____

☐ NO

History of:

☐ SI Details:_____

☐ HI Details:_____

☐ SIB Details:_____

Current

☐ SI Details:_____

☐ HI Details:_____

☐ SIS Details:_____

Referred clients most recent physical examination date_____

* If within the last 3 months please attach with this form

Current Medications and approximate initiation date (please list any medication prescribed even if referred is not taking as prescribed)

Medication Name:		Date of Initiation:		Taking as Prescribed?	
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Medication Name:		Date of Initiation:		Taking as Prescribed?	
Medication Name:		Date of Initiation:		Taking as Prescribed?	
Medication Name:		Date of Initiation:		Taking as Prescribed?	
Medication Name:		Date of Initiation:		Taking as Prescribed?	

Please attach to this application: chemical health assessment, mental health assessment, educational/ IEP information or any other collateral information relevant this review.

Please know securing a place on the WINGS waiting list on occurs upon participation in the WINGS phone screen and subsequent determination of adequate fit and perceived ability to sufficiently meet the referred client's needs.