St. Clair County Community Mental Health

Intensive Care Coordination with Wraparound (ICCW) Referral

Child & Family Services, 2415 24th Street, Port Huron, MI 48060
Attn: Rachel Krueger – Phone #: (810) 488-8868 – Email: rkrueger@scccmh.org - Fax #: (810) 941-8833

Referral Information

OASIS Case #: _____

Date of Referral:	Referring Agency:
Referring Person:	Referring Person's Title:
Referring Person's Email:	Referring Person's Phone #:
Referring Person's Address:	
Child's Name:	DOB:
Parent/Guardian #1:	Relation:
Email:	Phone #:
Parent/Guardian #2:	Relation:
Email:	Phone #:
Is the child a Temporary Court Ward (MDHHS or Juvenile Probation **or** MCI Ward? ☐ Yes ☐ No	
Worker #1:	Agency:
Email:	Phone #:
Address:	
Worker #2:	Agency:
Email:	Phone #:
Address:	

Living Arrangements

1. What is the child's current placement? (i.e., bio home, foster care, with family, etc.)

   _____

2. List the names of all household members, including the referred child:

Name	Relation to Referred Child	Age	Grade *(if applicable)*

Clinical Form: #03-0354
Revised Date: 12/5/2024
Policy Ref: #03-002-0025
EHR: Services, Wraparound Note: Authorization for the ROI

Natural Supports

3. What natural supports does the family have?*(These natural supports are individuals that can assist with the planning process, evaluation of interventions, and in some cases, have a part in the implementation of the plan.)*

Name	Relationship

4. Has the child been in foster care before? ☐ Yes ☐ No
5. Has the child been in a residential placement before? ☐ Yes ☐ No
6. Child & Family Strengths:

Education

7. Is the child presently enrolled in school? ☐ Yes ☐ No
    a. If yes, what grade is the child currently in? _____
    b. Name of School: _____
    c. Does the child have an Individualized Education Program (IEP)? ☐ Yes ☐ No
    d. Does the child have a 504 plan? ☐ Yes ☐ No
    e. Does the child have a behavior plan? ☐ Yes ☐ No
    f. Has the child been truant in the last 6 months? ☐ Yes ☐ No
    g. Has the child ever been suspended or expelled from school? ☐ Yes ☐ No
        i. Explain why & when: _____

Mental Health Services

8. List any services that the child/family has been involved with in the past:

Agency	Dates of Service	Type(s) of Service

9. List any previous hospitalizations:

Hospital Name	Date(s) of Hospitalization	Reason

10. Does the child receive services from St. Clair County Community Mental Health (SCCCMH)? ☐ Yes ☐ No
    a. If yes, who is their case holder? _____
11. If the answer to #10 is no, where are they currently receiving services? _____
    a. Would they be willing to switch to SCCCMH? ☐ Yes ☐ No
12. Has the child ever received Wraparound services before? ☐ Yes ☐ No
13. Is the child prescribed any psychotropic medications? ☐ Yes ☐ No
14. What is the child's current diagnosis? _____
15. Has the child been diagnosed with Autism? ☐ Yes ☐ No

Safety Indicators

In the last 90 days:

16. Has the child used drugs or alcohol? ☐ Yes ☐ No
    a. If yes, explain: _____
17. Has the child physically hurt themselves on purpose? ☐ Yes ☐ No
    a. If yes, explain: _____
18. Has the child made verbal statements about hurting themselves? ☐ Yes ☐ No
    a. If yes, explain: _____
19. Has the child physically hurt others on purpose? ☐ Yes ☐ No
    a. If yes, explain: _____
20. Has the child attempted to run away from home? ☐ Yes ☐ No
    a. If yes, how many times? _____

System Involvement

21. Identify the child's current involvement with the following agencies/systems:

☐ Department Human Services (DHS) ☐ Mental Health ☐ School ☐ Probation/Juvenile Justice (JJ)
☐ Teen Health Center ☐ Friend of the Court ☐ Police ☐ Other:

22. Explain involvement with Probation/Juvenile Justice or police:

23. If the child is on probation, who is their Probation Officer? _____
24. Has there been Child Protective Services (CPS) involvement in the last 6 months? ☐ Yes ☐ No

Clinical Form: #03-0354
Revised Date: 12/5/2024
Policy Ref: #03-002-0025
EHR: Services, Wraparound Note: Authorization for the ROI

Summary/Expectations

25. Explain why you feel Intensive Care Coordination with Wraparound (ICCW) is needed & what do you hope will be accomplished.

26. Are you requesting services through the Serious Emotional Disturbance Waiver (SEDW)? ☐ Yes ☐ No
    a. If yes, what is the most recent CAFAS/PECFAS score? *(within the last 30 days)* _____

Clinical Form: #03-0354
Revised Date: 12/5/2024
Policy Ref: #03-002-0025
EHR: Services, Wraparound Note: Authorization for the ROI