



Ho-Chunk Nation Coordinated Services Team

Referral Form

| | | | |
|------------------|--|------------------|--|
| Child's Name | | Address | |
| Date of Birth | | City, State, Zip | |
| HCN Enrollment # | | Phone # | |

An eligible child must meet 2 of the following direct services. Please check all that apply.

- Behavioral Health** (Mental Health, AODA Services)
- Medically fragile or physical disability**
- Academically Challenged** (ISFP, IEP, IHP, 504 Plans, RTI, truancy)
- Child Welfare Services** (Prevention, ICW, Child Protection, Juvenile Justice)
- Child is at risk for out of home placement, or is currently in out-of-home placement.
- Other interventions have not been successful over time; persistent obstacles to service access; and or there is a need for service coordination.
- Parents are willing to be involved in the voluntary Coordinated Services Team process**

Parent/Caregiver Information

| | | | |
|------------------|--|------------------|--|
| Mother Name | | Father Name | |
| Caregiver Name | | Caregiver Name | |
| Address | | Address | |
| Apt # | | Apt # | |
| City, State, Zip | | City, State, Zip | |
| Phone # | | Phone # | |

Significant Relationship with referred Child (Age & Relationship)

| | |
|-----------------|--|
| In the Home | |
| Not in the Home | |

Please explain how the Coordinated Services Team process would improve the child & family's current situation?



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I give my consent to _____ to refer my child and family members as identified to the Ho-Chunk Nation Coordinated Services Team Project. I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realized that as long as our family is involved in CST, it will be necessary for service providers to routinely review and share information.

Signature of Individual Authorizing Referral

Relationship to the Child

Date

Signature of Referring Provider

Relationship to the Child

Date

| | | |
|-------------------------------------|---------------|-----|
| Print Referring Provider and Agency | Phone Contact | Fax |
| | | |

Please submit this referral form and signed consent to
Ho-Chunk Nation Social Services Intake
By one of the following ways

Fax: (715) 284-0097

Scan and email to

CStintake@ho-chunk.com

Centralized Intake

808 Red Iron Road

Black River Falls, WI 54615