WALWORTH COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
1910 County Road NN P.O. Box 1005 Elkhorn, WI 53121-1005
262-741-3200

CHILDREN'S LONG TERM SUPPORT (CLTS) REFERRAL

CHILD'S INFORMATION

Last Name: __________________

First Name: __________________ MI: _______

Date of Birth (mm/dd/yyyy): __________________

Age: __________________

Gender: M ☐ F ☐ NON-BINARY ☐

Street Address: ____

City: __________________

State: __________________

Zip Code: __________________

County/Tribe of Residence: __________________

Phone Number: __________________

Is the child a U.S. citizen? YES ☐ NO ☐

Is the child a Wisconsin Resident? YES ☐ NO ☐

Social Security Number: __________________

Immigration Registration Number (If applicable): __________________

Primary Language the child speaks: __________________

PARENT/GUARDIAN INFORMATION

PARENT #1

Last Name: __________________

First Name: __________________

Address (if different from child): ____

County/Tribe of Residence: __________________
Phone Number: __________________

Leave Message? YES ☐ NO ☐

Best Time to Contact?: __________________

Interpreter Needed: YES ☐ NO ☐ If yes, language: __________________

PARENT #2

Last Name: __________________

First Name: __________________

Address (if different from child): ____

County/Tribe of Residence: __________________
Phone Number: __________________

Leave Message? YES ☐ NO ☐

Best Time to Contact?: __________________

Interpreter Needed: YES ☐ NO ☐ If yes, language: __________________

REFERRAL INFORMATION

CLIENT IS BEING REFERRED BY:

Organization and/or Person Name: __________________

Phone: __________________

Is the client aware the referral is being made? YES ☐ NO ☐

Email: __________________

Release of Information Included? *(Not Required)* YES ☐ NO ☐

CHILD'S DIAGNOSIS INFORMATION:

Diagnosis: __________________

Provider Name: __________________

Date of Diagnosis: __________________
Diagnosis: __________________

Provider Name: __________________

Date of Diagnosis: __________________

Diagnosis: __________________

Provider Name: __________________

Date of Diagnosis: __________________

IN THE PAST YEAR CHILD HAD INVOLVEMENT IN**:**

☐ Outpatient Counseling
☐ CCS
☐ Inpatients Hospitalization
☐ Youth Justice
☐ Birth to 3
☐ Crisis

<u>CURRENT PROVIDERS</u>

PHYSICIAN/PSYCHIATRIST:

Name: __________________

Provider Organization: __________________

OTHER THERAPISTS**:** __________________

Name: __________________

Provider Organization: __________________

Name: __________________

Provider Organization: __________________

Name: __________________

Provider Organization: __________________

MEDICAID SOURCE

☐ Forward Health (BadgerCare, Foster Care, other: __________________)

☐ Katie Beckett

☐ SSI

☐ No Source

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE CHILD AND THEIR CURRENT NEEDS:

NAME OF INDIVIDUAL COMPLETING REFERRAL: __________________

DATE COMPLETED: __________________

Please email form to: HHSCLTS@co.walworth.wi.us