CHRISTIAN FAMILY SOLUTIONS
WISCONSIN LUTHERAN CHILD & FAMILY SERVICE. INC.

Referral for Care Management Services - Behavioral Health Home Program

Send by EMAIL TO: BHHIntake@wlcfs.org

GENERAL INFORMATION

Participant's Name: _____ Date of Birth: _____

Parent/Caregiver Name: _____

Contact: ☐ Client ☐ Parent Preferred Contact ☐ Email ☐ Phone May we leave a message? ☐ Yes ☐ No

DIAGNOSIS

Does the client have a diagnosis of serious mental illness (SMI), substance use disorder (SUD) or emotional disturbance (ED)? ☐ Yes ☐ No ☐ Unsure

Current Therapist: _____

Date of Last Diagnostic Assessment: _____

Active Medical Assistance or PMAP health insurance benefits? ☐ Yes ☐ No ☑ Unsure

REFERRAL SOURCE INFORMATION

Name of Person Making Referral: _____

Support Services Requested (check as many as needed):

- ☐ Help accessing regular medical and mental health services
- ☐ Action planning to address health conditions and life situations
- ☐ Connection with social and community supports
- ☐ Help accessing financial and economic resources
- ☐ Coordination of health care and social service needs
- ☐ Information to help make healthy, informed choices
- ☐ Other_____

_____ _____

Referent Signature Date