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: _____

Email: _____

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 of child : _____

Is the child Hispanic or Latino? YES NO

What is the child's Race: _____

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: _____

Email: _____

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

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

CHILD'S DIAGNOSIS INFORMATION: *(List any pending diagnosis or evaluations)*

Diagnosis: _____

Provider Name: _____

Date of Diagnosis: _____

Diagnosis: _____

Provider Name: _____

Date of Diagnosis: _____

Diagnosis: _____

Provider Name: _____

Date of Diagnosis: _____

CHILD INVOLVMENT IN THE FOLLOWING PROGRAMS**:**

☐ Outpatient Counseling ☐ Youth Justice

☐ CCS ☐ Birth to 3

☐ Inpatient Hospitalization ☐ Crisis

CURRENT PROVIDERS

PHYSICIAN/PSYCHIATRIST:

Name: _____

Provider Organization: _____

OTHER THERAPISTS**:** _____

Name: _____

Provider Organization: _____

Name: _____

Provider Organization: _____

SCHOOL:

District/Name: _____

Does the child have an IEP? YES NO

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