TRAUMA ASSESSMENT REFERRAL/INVOICE

Michigan Department of Health and Human Services

Instructions: This form must be uploaded into MiSACWIS with the case service authorization and routed to FCD for approval.

REFERRAL

1a. Child Information

Name	Gender ☐ M ☐ F ☐ Transgender	Date of Birth
Ethnicity		
Is the child under age 3? If yes, provide the name of the professional that supports this referral and his/her role and agency.		
Name	Role	Agency ☐ Early On ☐ CMH – Infant Mental Health ☐ Pediatrician/Physician ☐ Other:

Child's Current Address	Telephone	Name of Child's Current Placement
MiSACWIS Child ID Number	MiSACWIS Case Number	
MiSACWIS Service Authorization Number	County of Jurisdiction	
Child's County of Residence	Program Type ☐ CPS ☐ FC ☐ JJ	
Type of Placement ☐ Foster Home ☐ Own Home ☐ Relative Home ☐ Guardian ☐ CCI ☐ Hospital ☐ Other:		Legal Status

1b. Referring Worker Information

Worker Name	Telephone	Email
Supervisor Name	Telephone	Email
MDHHS Monitor Name	Telephone	Email
MDHHS Monitor Supervisor Name	Telephone	Email
MDHHS Office or PAFC Agency Name	MDHHS Office or PAFC Address	

1c. Health Information (If not applicable, state N/A)

Is the child working with a Mental Health Counselor or Therapist? ☐ Yes ☐ No	
Agency and Name of Mental Health Counselor or Therapist	Telephone
Primary Care Physician/Pediatrician	Telephone
Is the child working with a Psychiatrist? ☐ Yes ☐ No	
Agency and Name of Psychiatrist	Telephone
Is the child working with a speech therapist? ☐ Yes ☐ No	
Agency and Name of speech therapist.	Telephone
Is the child working with an occupational therapist? ☐ Yes ☐ No	
Agency and Name of occupational therapist.	Telephone

Current Medications	Diagnosis (Medical and Mental Health)

1d. Parents, Caregivers and Other Adults to be Included in Assessment (parents must be included in assessment if TCW)

Name	Relationship to Child	Address	Email	Telephone
	☐ Legal Parent ☐ Foster Parent-Unrelated ☐ Foster Parent-Relative ☐ Relative ☐ Other:			
Name	Relationship to Child	Address	Email	Telephone
	☐ Legal Parent ☐ Foster Parent-Unrelated ☐ Foster Parent-Relative ☐ Relative ☐ Other:			
Name	Relationship to Child	Address	Email	Telephone
	☐ Legal Parent ☐ Foster Parent-Unrelated ☐ Foster Parent-Relative ☐ Relative ☐ Other:			

1e. Reason for Assessment

Comprehensive trauma assessment (service description 0037 - $1850.00)
Reason for assessment and summary of child's traumatic experiences, any developmental delays, changes in child's behavior, and concerns about attachment or emotional responses.
Current/Previous Services and Outcomes

1f. Approval Signatures

Worker Signature	MiSACWIS Service Authorization Number	Date
Supervisor Signature		Date
MDHHS Monitor Signature		Date
MDHHS Monitor Supervisor Signature		Date
MDHHS County Director/District Manager/Designee Signature		Date

1g. Referral Information

Referred to: ☐ New Oakland Child Adol. & Family Center ☐ Bethany Christian Services ☐ Easter Seals ☐ Eagle Village ☐ CTAC ☐ Child & Family Services Northwest ☐ Samaritas	Referral Date

Exception to use provider outside of rotation:

☐ Location of child and adult participants outside county of jurisdiction

☐ Provider already assessing sibling(s)

☐ Provider next in rotation is not able to schedule a timely appointment.

☐ Complexity of case requires expertise the provider next in rotation is unable to provide.

Explain:

☐ Provider next in rotation declines referral

Name of provider

☐ New Oakland Child Adol. & Family Center
☐ Bethany Christian Services
☐ Easter Seals
☐ Eagle Village
☐ CTAC
☐ Child & Family Services Northwest Michigan
☐ Samaritas

1h. Attachments

☐ Mental health records	☐ ISP	☐ USP	☐ Psychological
☐ Release of information	☐ Trauma screen	☐ Petition for removal	☐ Psychiatric evaluation
☐ IEP / 504	☐ Early On assessment		☐ No other documents
List other			

Ancillary Services (0038): If seeking approval for Ancillary Services, complete the MDHHS-5599 for pre-approval of the services.

Note: Referral is not complete without applicable documents and signatures from all applicable parties.

Instructions: Upload this document again once the service has been completed and the contractor has completed section 2a. Worker fills out section 2b, end dates the service in MiSACWIS when entering the manual payment.

INVOICE

2a. Provider/Vendor to Complete

Payee Name	Payee Phone Number	Amount Billed for Assessment
MiSACWIS Provider Name	MiSACWIS Provider Number	Amount Billed for Ancillary Services
Payee's Billing Address		Date of Service

2b. Service Worker to Complete upon return from Provider/Vendor

Trauma Assessment Received ☐ Yes ☐ No (cannot process payment until received)	Date Manual Payment Entered in MiSACWIS

Contracted Provider Name	**MiSACWIS Provider ID Number**
Bethany Christian Services	10382821
Child and Family Services of Northwestern Michigan	10400257
Eagle Village – Hainley	10297817
Easter Seals	10418690
New Oakland Child-Adolescent and Family Center – Ismail B. Sendi, MD PC	10268762
Samaritas	10436432
Western Michigan University CTAC	10412837

Worker Signature	Date
Date Manual Payment Entered in MiSACWIS	
Supervisor Signature	Date
The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.	