|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | | | Date of Birth |
|  | | | | | | | M | F | | | Transgender | | | |  |
| 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 | | | | | | | | | Legal Status | | | | | | |
| Foster Home | Own Home | Relative Home | | | | Guardian | | |  | | | | | | |
| CCI | Hospital | Other: | |  | | | | |  | | | | | | |
| **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 | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | | | | Referral Date |
| New Oakland Child Adol. & Family Center  Bethany Christian Services  Easter Seals  Eagle Village | | | | | | CTAC  Child & Family Services Northwest Samaritas | | | |  |
| 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 assessment | |
| Release of information | | Trauma screen | | Petition for removal | | | Psychiatric evaluation | |
| IEP / 504 | | Early On assessment | | | | | No other documents | |
| List other | | | | | | | | |
|  | | | | | | | | |
| **1i. 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 | | | | | Date Manual Payment Entered in MiSACWIS | | | |
| Yes | No (cannot process payment until received) | | | | |  | | |
| **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. | |