King County

Intensive Stabilization Services (ISS)
Referral Form

Referred By		*Date*		*Time*	
Agency		*Phone*		*Fax*	
Child's Name		*Referrer's Email*			

2 8 24

Instructions

Thank you for making a referral to the CCORS Intensive Stabilization Services Program. ISS is an intensive, in-home service for children, youth, and families where the functioning of the child and/or family is significantly impacted due to family conflict resulting from emotional or behavioral problems and where the current living situation is at risk of disruption or in need of immediate stabilization. Once enrolled in ISS services, families should expect to work frequently with the CCORS staff on skill building and behavioral management as well as other priority needs identified by the family.

Mental Health Clinicians: You are expected to continue providing mental health services to the child, and to be an integral part of the team throughout the course of the ISS intervention.

DCYF Social Workers: CFWS staff are expected to be an active part of the team throughout the intervention. However, if this is a CPS, FAR, FRS or Voluntary Services case, please work with CCORS-ISS until you must close the case according to timelines in DCYF policy.

Purpose of Referral:

☐ Hospital Diversion ☐ Placement Prevention ☐ Stabilize Living Arrangement

Has family been informed that a referral to ISS was made and that they will be contacted about accepting this service?

☐ Yes ☐ No

CLIENT INFORMATION:

Child's DOB		*Age*		☐ M ☐ F ☐ Transgender: Preferred Pronouns:	
Race / Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Multi-Racial			*Other*	

Child's Language		*Caregiver's Language*		*Tribe*	
Child's Address				*Apt #*	
City		*Zip Code*		*Phone #*	
Current Location	☐ ER ☐ Home	☐ Other			

Child's Legal Status	☐ Parental Custody ☐ Voluntary Placement Agreement	☐ Protective Custody ☐ Shelter Care	☐ State Dependent ☐ Guardianship
Residential Arrangement	☐ Birth Home ☐ Suitable Adult (natural support) ☐ Night by Night Placements ☐ Temp Placement ending on ☐ Other:	☐ Relative Placement ☐ Foster Home ☐ Adoptive Home ☐ Group Home	☐ Hospital ☐ CLIP Facility ☐ Detention ☐ Homeless (streets, etc)
Name & Relationship of who the child lives with:		*Work / Cell Phone*	
Other household Members:			

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Who has legal custody of the child?		*Child is adopted?*	☐ Yes ☐ No

Family Members:

Parent / Guardian		*Age*		Lives at Home? ☐ Yes ☐ No
Parent / Guardian		*Age*		Lives at Home? ☐ Yes ☐ No
Sibling's Name		*Age*		Lives at Home? ☐ Yes ☐ No
Sibling's Name		*Age*		Lives at Home? ☐ Yes ☐ No
Sibling's Name		*Age*		Lives at Home? ☐ Yes ☐ No

Natural Supports:

Name	*Relationship*	*Phone*	*Email*

MENTAL HEALTH INFORMATION

**** Describe the immediate concerns or behaviors that are causing the crisis: ****

Describe the expected stabilization goals for ISS to address. (Select any of the options, or add other items.):

- ☐ Help the caregiver / social worker identify the child's escalation process and how to effectively intervene in this.
- ☐ Instruct the child and caregivers on emotional regulation skills.
- ☐ Partner with the outpatient mental health provider to support the education of the caregiver / social worker about the child's diagnosis, the impacts of past trauma on behavior, or similar topics.
- ☐ Help the caregiver / social worker enroll or re-engage youth in outpatient mental health services. (Counseling, med mgmt., etc.)
- ☐ Provide brief in-home therapy to address immediate safety, communication, or similar issues to stabilize the child's placement.
- ☐ Facilitate a meeting between the caregiver/social worker and the child's school to discuss stabilizing the child in that setting.

Other Goals:

Safety Concerns:

Issue	*Means Available?*	*Youth has specific plan?*	*Explain the situation:*
Suicidal:	☐ Yes ☐ No	☐ Yes ☐ No	
Homicidal:	☐ Yes ☐ No	☐ Yes ☐ No	
Access to a weapon?	☐ Yes ☐ No	☐ Yes ☐ No	

Home Environment	
Psychotic Indicators	
Self-mutilation	
Onset of acuity	

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Mental Health Crisis Plan	Plan exists? ☐ No ☐ **Yes**, **MUST BE ATTACHED!**

Significant Changes in Functioning (past 30 days)

Appetite	
Sleep	
Self-Care	
Support Systems	
Property Destruction	
Physical Aggression	

Other Concerns:

☐ Hearing	☐ Vision	☐ Physical disabilities
☐ Developmental delays or intellectual disabilities	☐ Autism Spectrum diagnosis	☐ Sensory, communication, or similar challenges
☐ Other (explain):		

Current Mental Health Involvement:

☐ *Yes, complete this section.* ☐ *None at this time.*

Therapist's Name			*Phone*	
Supervisor's Name			*Phone*	
Agency		*Last Contact with Provider*		
Insurance	☐ *Private* ☐ *No Insurance*	*Medicaid* ☐ *Tier Benefit*	☐ *Other:* _____	

Current Diagnosis		
Prescribed Treatment Modality & Frequency	☐ Individual ☐ Family ☐ Group ☐ Med Mgmt	*Times per week or month:* *Times per week or month:* *Times per week or month:* *Times per week or month:*
Are the youth and/or family actively engaged in treatment?	☐ Yes ☐ No	*If no, explain:*

Goals on the child's mental health treatment plan:

1.
2.
3.
4.

Past suicide attempts	*Method:*	*Dates:*
Past assaultive behavior	*Method:*	*Dates:*
Past outpatient treatment	*Location:*	*Dates:*
Psychiatric hospitalization	*Location:*	*Dates:*

Prescribing Dr / ARNP	*Name:*	*Agency:*	*Phone:*
Psych Medication 1	*Name:*	*Reason:*	*Dose:*
Psych Medication 2	*Name:*	*Reason:*	*Dose:*
Psych Medication 3	*Name:*	*Reason:*	*Dose:*
Psych Medication 4	*Name:*	*Reason:*	*Dose:*
Psych Medication 5	*Name:*	*Reason:*	*Dose:*

Other Systems Involved:

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Primary Care Physician:		*Phone:*	
Current Physical Health Issues:	☐ *Yes, describe:*	☐ *No*	

Current WISe / Wraparound Involvement:

Facilitator's Name		*Phone:*	
Agency:		*Next team meeting date:*	
Comments:			

Current Substance Use/Abuse/Treatment: ☐ *No* ☐ *Yes, explain below:*

Type (alcohol, marijuana, etc.)	*Quantity / Frequency*
Treatment Provider's Name & Agency:	Dates:

Current Department of Children, Youth & Families Involvement: ☐ *No* ☐ *Yes:*

Social Worker	*Name:*	*Phone:*
Supervisor	*Name:*	*Phone:*
Office	☐ King West ☐ Martin Luther King ☐ King East (Bellevue) ☐ Adoptions	☐ Kent SE ☐ Kent SW ☐ White Center ☐ OICW
Program	☐ Child Protective Services (CPS) ☐ Child and Family Welfare Services (CFWS)	☐ Family Voluntary Services (FVS) ☐ Family Reconciliation Services (FRS)
Why is CA involved with the family? (1-2 sentences)		
Current Services being provided:		

Current Juvenile Justice Involvement: ☐ *No* ☐ *Yes*

Assigned Parole, Probation, or Case Manager	*Name:*	*Phone:*
Office:	☐ ARY ☐ CHINS	☐ Truancy ☐ Offender
Charges:		

School Information:

School Name & District			*Grade:*
School Contact Person			*Phone:*
School Attendance	☐ Enrolled ☐ Other (explain):		☐ Suspended ☐ Not Enrolled
Is child on an IEP or 504 plan?	☐ No ☐ Yes	Reason:	

Please use additional pages as necessary.

INSTRUCTIONS:

Mental Health Referrals = Fax to Behavioral Health & Recovery Division (206) 205-1634. Attn: Sandy Tomlin

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Children's Administration Referrals

1. Make sure your supervisor is aware of this referral and approves.
2. Staff the case with Gatekeeper Karen Rall 206-639-6213.
3. Once the Gatekeeper give verbal approval, complete this referral form and email it to them.

FOR KING COUNTY / DCYF USE ONLY

Approved	*Signature*	*Title*	*Date*
☐ Yes ☐ No		Sandy Tomlin, LICSW Wraparound Program Specialist, Behavioral Health & Recovery Div	
☐ Yes ☐ No		Karen Rall Program Manager Dept of Children, Youth & Families	
Other comments			