WellPower

CHILD & FAMILY SERVICES

External Referral | Skyline Academy Day Treatment

Thank you for your interest in WellPower's Skyline Academy Day Treatment Program! ! If you are an outside service provider, parent/guardian, or case/social worker from the Department of Human Services, please complete this referral packet and email it to **skylinereferral@wellpower.org** for review of eligibility. Skyline Academy will confirm receipt of the completed referral packet within 24 business hours.
Please note that WellPower does not automatically work with all insurance providers or individuals/families that are referred to us. Should you have any questions, please contact the Program Manager at (303) 300-6270.

Referral Date: _____

Person Referred Information

Preferred Name: _____ Pronouns: _____ Gender: _____

Legal Name: _____ DOB: _____ Legal sex: _____

Address: _____ Preferred Language: _____

City, State, Zip: _____

Legal Guardian/Medical Decision Maker Information

Name: _____ Relationship to Referred: _____

Phone: _____ Email: _____

Preferred Language: _____ Reside together: ☐ No ☐ Part-time ☐ Full-time

Address: _____

Name: _____ Relationship to Referred: _____

Phone: _____ Email: _____

Preferred Language: _____ Reside together: ☐ No ☐ Part-time ☐ Full-time

Address: _____

Referring Agency Information

Is referral being made by parent/legal guardian? ☐ No ☐ Yes *(If yes, skip this section)*

Contact Name: _____ Phone: _____

Title: _____ Email: _____

Organization: _____

DHS Information (if applicable)

ATTENTION DHS
Please attach Family Services Plan

Is the child involved with Department of Human Services? ☐ Yes ☒ No

Case Worker Name: _____ County: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Is it okay to contact guardian/MDM? ☐ Yes ☐ No

Name: _____

Phone: _____

Email: _____

Preferred Language: _____

Relationship to referred: ☐ Bio Parent ☐ Adoptive Parent ☐ Other – Please specify: _____

Is legal guardian able to sign intake paperwork? ☐ Yes ☐ No

If "no," who can? _____

Phone: _____ Email: _____

Relationship to referred: ☐ Bio Parent ☐ Adoptive Parent ☐ Other – Please specify: _____

Legal Name (please print) _____ Date of Birth _____ Date of Referral _____

Who does the referred live with? ☐ Legal Guardian ☐ Kinship/Foster Family ☐ Group Home
☐ Other – Please specify: _____

Name (if not legal guardian): _____

Phone: _____ Email: _____

Is there a GAL? ☐ No ☐ Yes – please specify below:

If "yes," has LAN been filed? ☐ No ☐ Yes – **please include supporting legal documentation.**

GAL Name: _____ Phone: _____ Email: _____

Referred Health Insurance Information

Does referred have health insurance? ☐ Yes - what type: ☐ Medicaid ☐ CHP+ ☐ Other – please specify: _____
☐ No

Medicaid/Insurance ID#: _____

School Information

Grade Level: _____ Teacher's Name: _____

School Name: _____ District: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Special Education: ☐ No ☐ Yes – 504 Plan ☐ Yes – IEP *(If yes, include records with referral.)*

Referral Information

Has the referred or legal guardian been notified of the referral? ☐ Yes ☐ No

Has participation in services been court ordered? ☐ Yes ☐ No

Reason for Referral (Provide a detailed summary of why this person needs day treatment services)**:**

CHILD'S HISTORY

Have there been any problems for this child in the following areas:

	Yes	No	UNK	Comments / Additional Information
EARLY DEVELOPMENT				
Mother's pregnancy	☐	☐	☐	
Exposure to substances in utero	☐	☐	☐	
Delivery of child	☐	☐	☐	
Feeding	☐	☐	☐	
Sleeping	☐	☐	☐	
Speech development	☐	☐	☐	
Motor development	☐	☐	☐	
Toilet training	☐	☐	☐	

Legal Name (please print) | Date of Birth | Date of Referral

DETAILS OF CURRENT/PAST MENTAL HEALTH TREATMENT:

Provide information on current and past mental health services including dates of treatment, the type of treatment (outpatient, inpatient, IOP, PHP, etc.), the provider name/organization, and reason for termination (if applicable).

SUBSTANCE USE

Nicotine	☐	☐	☐	
Alcohol	☐	☐	☐	
Marijuana	☐	☐	☐	
Other:	☐	☐	☐	

SCHOOL

Learning Disability	☐	☐	☐	
Behavior	☐	☐	☐	
Disciplinary Action	☐	☐	☐	
Suspension(s)/Expulsion(s)	☐	☐	☐	
Special Education	☐	☐	☐	

LEGAL INVOLVEMENT

Past arrest(s) / charge(s)	☐	☐	☐	
Charge(s) pending	☐	☐	☐	
Adjudication(s)	☐	☐	☐	
Incarceration(s)	☐	☐	☐	

BEHAVIOR

Physical Aggression	☐	☐	☐	
Suicide Attempt(s)	☐	☐	☐	
Suicidal Thoughts(s)	☐	☐	☐	
Self-Harm	☐	☐	☐	
Running Away	☐	☐	☐	
Property Destruction	☐	☐	☐	
Theft	☐	☐	☐	
Sexually Offensive Behavior	☐	☐	☐	
Other:	☐	☐	☐	

TRAUMA HISTORY

Physical Abuse	☐	☐	☐	
Emotional Abuse	☐	☐	☐	
Sexual Abuse/Assault	☐	☐	☐	
Neglect/Abandonment	☐	☐	☐	
Environmental Disaster	☐	☐	☐	
Medical Abuse	☐	☐	☐	
Other Traumatic Event	☐	☐	☐	

Legal Name (please print) | Date of Birth | Date of Referral

FAMILY HISTORY

Has or does any member of the child's family (immediate or extended) have a history of any of the following:

	Yes	No	UNK	Relationship	Comments / Additional Information
MENTAL HEALTH					
Depression	☐	☐	☐		
Suicide Attempt(s) / Completion	☐	☐	☐		
Anxiety	☐	☐	☐		
Bipolar or Manic Depression	☐	☐	☐		
Other mood disorder	☐	☐	☐		
Schizophrenia	☐	☐	☐		
Other psychotic disorder	☐	☐	☐		
LEGAL INVOLVEMENT					
Arrest(s)/Charge(s)/Incarceration(s)	☐	☐	☐		
SUBSTANCE USE					
Abuse / Dependency	☐	☐	☐		

Additional Considerations (Relevant Cultural Information, Family Needs, etc.)**:**