WASHINGTON COUNTY
Oregon

CHILDREN'S INTENSIVE SERVICES
REFERRAL FOR ELIGIBILITY DETERMINATION FOR

Intensive Service Array (ISA) ☐ **Wraparound Demo** ☐

All requested information MUST be provided. Incomplete forms will be returned to the referrer.

YOUTH INFORMATION

Client Name: ____________________ Date of Birth: __________ Age: _____

Oregon Health Plan? Yes ☐ No ☐ If yes, Prime ID:

Referred by: ____________________ Relationship: ____________________

Phone: ________________ Fax: ____________________

Current Mental Health Provider: ________________________

Primary Care Provider: ______________________________

Current School: ______________________________
IEP? Yes ☐ No ☐

GUARDIAN INFORMATION

Name: ________________________ Relationship: ____________________

Address: ____

City: ________________ Zip: _______ Phone: ____________________

Placement Information, if youth does not live with guardian:

Name: ________________________ Relationship: ____________________

Phone: ________________

Emergency Contact: __________________ Phone: ____________________

Department of Health & Human Services – Mental Health and Developmental Disabilities
155 N First Ave, MS #70; Hillsboro, OR 97124
(503) 846-4528
(503) 846-4560 Fax

INSURANCE INFORMATION

Does youth have insurance in addition to the Oregon Health Plan? Yes ☐ No ☐

Policy Holder: ______________________ Insurance Carrier: ____________________________

Policy Number: ___________________ Group Number: ______________

No insurance Yes ☐ No ☐

WASHINGTON COUNTY USE ONLY

Date of Initial Request:_________________ Additional info. needed? Y / N

Date Requested: _____________ Date Received: ______________

Date Referral complete: __________ **Date of Determination**:_____________

ISA eligible? Yes ☐ **No** ☐ **CASII/ECSI Score:** ____ **Level:** _____

Wrap eligible? Yes ☐ **No** ☐ **Referred to Wrap? Yes** ☐ **No** ☐ If eligible but not referred, why? ____

Referral Source Notified: Yes ☐ No ☐ Family Notified? Yes ☐ No ☐ N/A ☐

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Axis I Dx Codes: ______________ ______________

______________ ______________

Insurance:
MCO ☐ Open Card ☐ Commercial ☐ GF ☐ None ☐

Ethnicity: White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐
Other ☐ (indicate)___________________________

Signature of Person conducting determination: __________________________________