



# Community Integrated Health Services

## Wraparound with Intensive Services (WISe) Referral Form

Our WISe Outpatient program offers a full spectrum of behavioral health services. Based on individuals needs we can provide mental health services to include case management, prescriber services, and peers.

**This is a voluntary program for individuals who are eligible for Medicaid**, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

### Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email [Scheduling@cihealthservices.com](mailto:Scheduling@cihealthservices.com)
  - Fax: (844) 497-2430 or (360) 558-7189
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one business day of receipt of request.
- Check the county where you anticipate services being provided:
  - Cowlitz       Lewis       Grays Harbor       Pacific
- How did you hear about us? \_\_\_\_\_

### Referent Information

Are you Self Referring?  Yes  No (if yes skip to next section)

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

### Individual Requesting Services

First & Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Preferred Gender Pronoun: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

If the Youth is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the youth does not wish to have Medicaid Insurance statements or other treatment-related correspondence sent to the above mailing address please mark this box:

**If the Youth is 13 years of age or older; does that Youth want their parent/guardian to have knowledge of the referral:**  Yes  No

**Parent/Guardian Information**

First & Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

First & Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

First & Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for Requesting Services**

Examples: homicidal and/or suicidal ideations, substance use/abuse, depression, trauma stressors, multi-system involvement, family functional difficulties, etc.

**Diagnosis (If Known) and/or Symptoms**

**Community Integrated Health Services Mailing Addresses:**

**Cowlitz County:** 1116 14<sup>th</sup> Avenue, Longview, WA 98632

**Grays Harbor County:** 618 W. Market Street, Aberdeen, WA 98520

**Lewis County:** 1707 Cooks Hill Road, Centralia, WA 98531

**Pacific County:** 335 Third Street, Raymond, WA 98577

**Pacific County:** 152 First Ave North, Ilwaco, WA 98624

Phone: (360) 261-6930 or (855) 303-4834 | Fax: (360) 748-4480 or (844) 554-3370

Website: [www.cihealthservices.com](http://www.cihealthservices.com)

**For Office Use Only:**

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Received Via:  Email  Fax  Mail  In-Person  Other \_\_\_\_\_

Provider One # \_\_\_\_\_