# 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 andany additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email 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 beingprovided:

  ☐ Cowlitz ☐ Lewis ☐ Grays Harbor ☐ Pacific ☐ Wahkiakum

- How did you hear aboutus? _____

**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 and Avatar ID:_____Date:_____

Birthdate:_____Preferred Gender Pronoun: _____

Home Address: _____

City:_____State:_____Zip:_____

Email Address: _____

Cell Phone:_____Home Phone: _____

School Attending: _____

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:** 1128 Broadway, Longview, WA 98632

**Grays Harbor County**: 110 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

**Wahkiakum County**: 427 Columbia Street, Cathlamet, WA 98612

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

Website: www.cihealthservices.com

**For Office Use Only:**

Received By:_____ Date:_____

Received Via: ☐ Email ☐ Fax ☐ Mail ☐ In-Person ☐ Other_____

Provider One # _____