

**CFFA WRAP-AROUND SERVICES AUTHORIZATION UAS 518 Form #5 Page 1 of 2**

INDICATE APPLICATION TYPE WITH A CHECK (✓):

- In-Home Intensive Treatment (95)
- In- Home Case Mgt (71)
- Transportation Services (53)
- Other Reimbursable service (12)
- Summer Safety/Summer Enrichment (80)
- Crisis Intervention ( 24 or  47)
- Court appearance or testimony (88)

COUNTY NAME:

PARENT'S NAME: (LAST)

PARENT'S ADDRESS

(FIRST)

COUNTY CODE

PARENT'S CASE #:

PARENT'S PHONE #

**FAMILY INFORMATION (LIST ALL CHILDREN IN THE HOME):**

	LAST NAME	FIRST NAME	DOB	RELATIONSHIP TO PARENT	GENDER	RACE
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

**PLACEMENT INFORMATION**

CHILD'S NAME	PLACEMENT (Name or Agency)	ADDRESS	TELEPHONE #

**COMPLETE FOR REPORTING PURPOSES ON THE PRIMARY PARENT:**

- Marital Status: 1.  Single    2.  Married    3.  Separated    4.  Divorced    5.  Widowed
- Education: 1.  < HS    2.  HS    3.  Other: \_\_\_\_\_
- Race: 1.  White    2.  Black    3.  Asian    4.  Hispanic    5.  Other: \_\_\_\_\_
- Income: 1.  TANF    2.  SSI    3.  Employed: approximate mo. income \_\_\_\_\_
- Placement Reason: 1.  Neglect    2.  Phy. Abuse    3.  Sex. Abuse    4.  Emo. Abuse    5.  Other
- Prior CPS Case: 1.  No    2.  Yes (reason):  N  P  S  E Other: \_\_\_\_\_
- Prior Placement: 1.  No    2.  Yes (reason):  N  P  S  E Other: \_\_\_\_\_
- Length of time case has been open 1.  <2 mo.    2.  2-6 mos.    3.  7-12 mo.    4.  >1 year

Case Summary: *(Specify documented service needs of the family):*

<b>INSTRUCTIONS:</b>		<b>COMPLETE THE APPROPRIATE COLUMN BASED ON APPLICATION TYPE. SEPARATE APPLICATIONS MUST BE MADE FOR EACH PROGRAM.</b>	
<input type="checkbox"/> In-Home Intensive (Code 95)	<b>In-Home Case Management</b> <input type="checkbox"/> Code 71	<b>Crisis Intervention</b> <input type="checkbox"/> Code 24 Prevent Placement <input type="checkbox"/> Code 47 Behavioral Mgt.	<input type="checkbox"/> Summer Safety/Enrichment (Code 80)
<b>Active Social Services Case Type (check one):</b>	<b>Active Social Services Case Type (check one):</b>	<b>Active Social Services Case Type (check one):</b>	<b>Active Social Services Case Type (check one):</b>
<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION	<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION	<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION	<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION
<b>AUTHORIZATION AMOUNT:</b>	<b>AUTHORIZATION AMOUNT:</b>	<b>AUTHORIZATION AMOUNT:</b>	<b>AUTHORIZATION AMOUNT:</b>
Clinical Services will be limited to a maximum of 180 days contracted at a rate of \$60 per hour plus mileage at a rate of \$0.28 cents per mile  MAXIMUM AMOUNT PER FAMILY IS: \$ 3,500.. The cost of any associated transportation is included in this maximum.	The contracted rate for professional services is \$45.00 per hour, and paraprofessional services is \$30 per hour, plus mileage at a rate of \$0.28 per mile.  MAXIMUM AMOUNT PER FAMILY IS: \$ 5,000. The cost of any associated transportation is included in this maximum.	The contracted rate is \$60.00 per hour for professional services and \$30.00 per hour for paraprofessional family services. Transportation of the client is reimbursed at \$0.28 per mile.	A maximum of \$252.00 per child per summer.
<input type="checkbox"/> Transportation Services (Code 53) <b>Active Social Services Case Type (check one):</b>	<input type="checkbox"/> Per diem – professional court appearance (Code 88) <input type="checkbox"/> Per diem – paraprofessional court appearance (Code 88) <b>Active Social Services Case Type (check one):</b>	<input type="checkbox"/> Other Reimbursable Service (12) <b>Check Case Type</b>	
<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION	<input type="checkbox"/> FC <input type="checkbox"/> ADOPTION	<input type="checkbox"/> FC <input type="checkbox"/> Adoption <input type="checkbox"/> Other	
<b>AUTHORIZATION AMOUNT:</b> \$.28 per mile for client transportation services, billed from provider residence, official business address, or county DFCS custody county, whichever is nearer to the destination point.	<b>AUTHORIZATION AMOUNT:</b> The contracted rate is \$50.00 per hour for a professional court appearance or testimony, if required more than sixty (60) days after the Assessment date referred.  The contracted rate is \$50.00 per hour for a professional court appearance or testimony, if required more than sixty (60) days after the Assessment date referred.	<b>MUST EXPLAIN</b>	
		SIGNATURE OF APPROVING AUTHORITY	
		DATE	
ROUTING INSTRUCTION: ORIGINAL REMAINS IN CASE RECORD -- COPY TO LOCAL COUNTY ACCOUNTING UNIT			

# REFERRAL FOR WRAP-AROUND SERVICES

FORM # 6 Page 1 of 2

Indicate Application Type (Check all that apply)

<input type="checkbox"/> In-Home Intensive (Code 95)	<input type="checkbox"/> In-Home Case Management (Code 71)
<input type="checkbox"/> Crisis Intervention (Code 24)	<input type="checkbox"/> Transportation Services (Code 53)
<input type="checkbox"/> Crisis Intervention (Code 47)	<input type="checkbox"/> Summer Safety/Enrichment (Code 80)
<input type="checkbox"/> Court Appearance or Testimony (Code 88)	<input type="checkbox"/> Other Reimbursable Service (Code 12)

Maltreatment (check all that apply):  Physical  Neglect  Sexual  Emotional  
 Other

County Name \_\_\_\_\_ County Code: \_\_\_\_\_  
 Parent's Name \_\_\_\_\_ Parent's Case # \_\_\_\_\_  
 Parent's Address \_\_\_\_\_  
 Parent's Telephone # \_\_\_\_\_

DFCS Foster Care Case manager: \_\_\_\_\_ Phone/Fax/Pager: \_\_\_\_\_

DFCS Supervisor Name: \_\_\_\_\_ Phone/Fax/Pager: \_\_\_\_\_

CASA Name: \_\_\_\_\_ Phone/Fax/Pager: \_\_\_\_\_

FAMILY INFORMATION (LIST ALL MEMBERS IN THE PARENT'S HOUSEHOLD):					
Last Name	First Name	DOB	Relationship To Parent	Gender	Ethnicity

Ethnicity: B--Black      W--White      A--Asian      AI--American Indian or Alaskan Native  
 H--Hawaiian or Pacific Islander      U--Unable to Determine      HL--Hispanic/Latino Origin:      HLU--Unable to Determine

PLACEMENT INFORMATION			
Child's Name	Placement (Name or Agency)	Address	Telephone #

**REFERRAL FOR WRAP-AROUND SERVICES** FORM # 6 Page 2 of 2

Family strengths: \_\_\_\_\_

---

---

---

---

---

---

---

---

Documented needs of the family: \_\_\_\_\_

---

---

---

---

---

---

---

---

Date of Removal: \_\_\_\_\_ Reason Child Was Removed: \_\_\_\_\_

---

---

---

---

---

---

Referred to (Name of Provider): \_\_\_\_\_

Referral Date: \_\_\_\_\_

Expected Service and Family or Child Outcome: \_\_\_\_\_

---

---

---

---

---

---

Expected Cost of Services Authorized: \_\_\_\_\_

Print Name--Person Completing Form/Signature:  
\_\_\_\_\_

**Comments** (use additional sheet as necessary):