WRAPAROUND WITH INTENSIVE SERVICES (WISe)

Wraparound with Intensive Services (WISe) is a family-centered, individualized, and strength-based intensive service for Medicaid-eligible children and youth from birth to 21 years old in King County, and non-Medicaid eligible youth in Pierce County, outside of Tacoma.

King County WISe
KCWISe@senecacenter.org
(206) 490-0985

Pierce County WISe
PierceWISe@senecacenter.org
(253) 356-8459

Our specific service map is located on our website (www.senecafoa.org)

WISe Care Team Includes:

- Mental Health Clinician
- Care Coordinator
- Family Partner
- Youth Partner
- Family
- Community Support

SENECA
FAMILY OF AGENCIES | UNCONDITIONAL CARE

Pierce County WISe Referral Form

Call: 253-356-8459; Email: piercewise@senecacenter.org
Or send via confidential fax (510-830-3596)

Date of Referral:	**Office Only**
Name of Referent:	INTAKE APPT DATE & TIME:
Referent Phone No.:	THERAPIST ASSIGNED:
Referent Email:	SCHEDULED BY:
Relationship to Client:	SCHEDULED ON:

CLIENT INFORMATION

Name:	DOB:	Age:
Ethnicity:	Primary Language:	
Gender:	Pronouns:	
Child/Youth Primary Address:		
Child/Youth Phone:	Voicemails ok? Yes ☐ No ☐	
Primary Caregiver(s) Name/Relationship to Youth:		
Phone:	Voicemails ok? Yes ☐ No☐	
Email:	Primary Caregiver Language:	
What school does the youth attend?		
Do you have primary insurance? Yes ☐ No ☐	Primary Insurance:	
Other Important Adults/Family Member(s)		
Name:	Relationship to Child/Youth:	
Name:	Relationship to Child/Youth:	

REASON FOR REFERRAL

Presenting Symptoms (please circle all that apply):

Suicidal Ideation ☐	Depressed Mood ☐	Tearful/Cries Often ☐	Hyperactive ☐
Suicide Attempt ☐	Social Withdrawal ☐	Easily Distracted ☐	Poor Impulse Control ☐
Physical Aggression ☐	Verbal Aggression ☐	Anxious ☐	Fidgety ☐
Paranoia ☐	Hypervigilant ☐	Obsessive Thoughts ☐	Compulsive Behavior ☐
Self-Mutilation ☐	Phobias ☐	Bedwetting ☐	Nightmares ☐
Hallucinations ☐	Disrupted Sleep ☐	Harmful to animals ☐	Drug Use ☐
Homicidal Ideation ☐	Weight loss/gain ☐	Poor social skills ☐	Disrupted Attachment ☐

Reasons for Referral to Therapy:

Previous behavioral/mental health treatment? No ☐ Yes ☐

CONTACT (Check all that apply)

Best days to contact: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐

INTAKE AVAILABILITY (Check all that apply)

Best days for meeting: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐

Pierce County HUMAN SERVICES

OFFICE ONLY	
Client has active Medicaid with qualifying benefits plan: Yes ☐ No ☐	Eligibility check completed on:
Is client receiving MH services with another agency? Yes ☐ No ☐	
Notes:	

CLIENT CONTACT & INTAKE TACKER (OFFICE ONLY)				
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Notes:				
When the referral is completed please pass on to assigned therapist, HIS & Program Supervisor				