Wings Referral Application

Please complete this form to the best of your ability. Please include, if available with this form the following: * Chemical Health Assessment *Mental Health Assessment
*Education or IEP documents.
Please know securing a place on the WINGS waiting list occurs upon participation in the WINGS phone screen and subsequent determination of adequate fit and perceived ability to sufficiently meet the referred client's needs.

Please FAX to 320-316-2383 or email to Info@WINGSATS.COM

Client Information

Client Name Preferred name

Client Current Address, city, state and zip

Client phone number Date of Birth Age

Sex Gender Identity Preferred pronouns

Is the client a current IV user? Yes No Is the client pregnant Yes No Male

Is the client willing to participate in a phone screen Yes No

Is the client willing to engage in educational services and work toward a diploma? Yes No

Need for residential services as soon as available? Yes No

Review as a backup plan for a lower level of care. Yes No

Who has custody of at time of Admission: Sole Select One Legal Select One Joint Custody Select One

additional information:

Funding Information:

Primary Insurance

Policy ID Group #

Secondary Insurance

Policy ID Group # MA PMI

Parent Guardian Information:

Parent/Guardian #1 Relationship

Contact phone # Email

Current Address, city, state and zip

Does parent/guardian have (check if applicable)

Physical custody Sole legal custody Joint legal custody

Parent/Guardian#2 Relationship

Contact phone # Email

Current Address, city, state and zip

Does parent/guardian have (check if applicable)

Physical custody ☐ Sole legal custody ☐ Joint legal custody ☐

Referring Agency:

Agency Name:

Contact person #1 with Agency

Email Phone number and extension.

Contact person #2 with Agency

Email Phone number and extension.

External Care Team:

Social Worker: County

Phone (include extension) Email

Probation officer County

Phone (include extension) Email

SUD Assessor:

Name Organization

Phone (include extension) Email

Other care members involved in client's treatment:

Name Agency

Phone (include Extension) Email

Relationship with Client

Name Agency

Phone (include Extension) Email

Relationship with Client

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Treatment accommodations:

Will interpreter services be needed? Yes ☐ No ☐ If yes, what language will be needed

Are there any special services that will be needed?

Are there any dietary restrictions?

History of referred client's participation of lower level of care (please list all places of care and termination dates

1.

2.

3.

4.

Rational to forego to a lower level of care prior to residential:

Does client have any medical needs carrying the potential to create barrier to residential treatment (physical limitations to participation in recreational activities, phobias, or unwillingness to consent to blood draw for admission physical, requirements of opioid pain relivers for current or recent injury, misc. other

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Does the referred client have a history of physical aggression (if yes, please explain)

Are there any potential barriers that could interfere with residential treatment?

History of:

Suicidal ideations – Details:

Homicidal ideations – Details

Self-injurious behaviors – Details

Current:

Suicidal ideations – Details:

Homicidal ideations – Details

Self-injurious behaviors – Details

Current medications and approximate initiation date (please list all medications currently prescribed even if client is not taking as prescribed)

1.Medication Name

Date of initiation **Taking as prescribed** Yes No

2. Medication Name

Date of initiation **Taking as prescribed** Yes No

3. Medication Name

Date of initiation **Taking as prescribed** Yes No