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

Need for residential services as soon as available? ☐ Review as a backup plan for a lower level of care? ☐

Client Information

Client Name _____ Preferred name _____

Phone number _____ Date of birth _____

Sex _____ Gender identity _____ Preferred pronouns _____

Is the client a current IV user? (Yes/No) ☐ Is the client pregnant (Yes/No) ☐

Is the client willing to participate in a phone screen (yes/no) _____

Parent/Guardian Information:

Parent/Guardian #1 _____ Relationship _____

Contact phone # _____ Email _____

Current city, state, and zip code _____

Does parent/guardian have (check if applicable): Physcial Custody ☐ Sole legal custody ☐ Joint legal custody ☐

Parent/Guardian #2 _____ Relationship _____

Contact phone # _____ Email _____

Current city, state, and zip code _____

Does parent/guardian have (check if applicable) Physical Custody ☐ Sole legal custody ☐ Joint legal custody ☐

Funding information (this must be filled out completely)

Primary Insurance _____

Policy ID _____ Group # _____

Secondary Insurance company _____

Policy ID _____ Group _____

Medical Assistance # _____

WINGS Referral Application

External care team

Social worker name: County

Phone (include extension) Email

SUD assessor name Email

Phone(include extension)

Agency that performed the SUD assessment

Probation officer County

Phone(include extension) Email

Other care members involved in client's treatment:

Name Agency

Phone(include extension) Email

Name Agency

Phone(include extension) Email

Special Needs:

Will interpreter services be needed? If yes, what language will be needed?

Are there any special services that will be needed

Are the any dietary restrictions?

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

1

2

3

Rational for going to 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, requirement of opioid pain relievers for current or recent injury, misc. other)

WINGS Referral Application

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

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

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

History of:

Suicidal ideation Details:

Homicidal ideation Details:

Self injurious behaviors Details:

Current:

Suicidal ideation Details:

Homicidal ideation 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.

Medication Name		Date of Initiation		Taking as prescribed (Y/N)	
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