Wings Referral Application

Please complete this form to the best of your ability.

Please include, if available with this form the following:

* Substance Use 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 approval determination.

Please fax to 320-316-2383 or email to Info@Wingsats.com

Client Information

Client Name _____ Preferred Name _____ Date of Birth _____
(First, Middle and last)

Client Current Address, City, State and Zip _____

Client Phone Number _____

Sex _____ Gender Identity _____ Preferred Pronoun _____

Will interpreter services be needed? ☐ Yes ☐ No ☐ If so, what language _____

Is the client a current IV user? ☐ Yes ☐ No

Is the client pregnant? ☐ Yes ☐ No ☐ N/A

Does the client have children? ☐ Yes ☐ No

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

Present location of the child? _____

Present location contact information (REQUIRED) _____

Is the client willing to engage in educational services? ☐ Yes ☐ No

Urgency of Need

Please Select One

Funding Information

Primary Insurance _____ Policy ID _____ Group _____

Secondary Insurance _____ Policy ID _____ Group _____

MA/PMI Number _____

Guardian Information

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 ☐ No custodial rights

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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 ☐ No Custodial Rights

Referring Agency

Agency Name

Contact Person #1 with agency Email

Phone and Extension Have you referred to Wings before?

If no, how did you hear about Wings.

Contact person #2 with agency Email

Phone and Extension

External Care Team

Social Worker County

Phone (include extension) Email

Probation Officer County

Phone (include extension) Email

Substance Use Assessor

Name Organization

Phone (include extension) Email

Other Care Team Member 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

Individualized need (Check all that apply)

☐	Mediation Assisted Therapy (MAT) Suboxone/Sublicade	☐	Grief/loss Counseling
☐	Mood Disordered Dervices	☐	Disordered Eating
☐	Psychosis Management	☐	Diet and Exercise Specific Services
☐	Treatment/Management of Chronic Medical Condition	☐	Culturally Specific Services
☐	Anger Management	☐	Other:

Dietary Restrictions:

Therapeutic Services History (List most recent first – Please list all places of care for no less than 3 years)

1. Services Provider Level of Care

Service Introduction Date

Service Termination Date

Discharge Status Please Select from the Following

2. Services Provider Level of Care

Service Introduction

Service Termination

Discharge Status Please Select from the Following

3. Services Provider Level of care

Service Introduction

Service Termination

Discharge Status Please Select from the Following

4. Services Provider Level of care

Service Introduction

Service Termination

Discharge Status Please Select from the Following

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Demenstration of medical necessity. (Please identify how less restrictive settings would be insufficient in meeting needs.)

Barriers to treatment progression (check all that apply)

☐	Physical Limitations to Participate in Recreational Activities	☐	Fear/Phobias
☐	Unwillingness to Consent to Blood Draw for Admission Physical	☐	Medical Management Apprehension, Non-compliance, or Policy Conflict, Concerns
☐	Support System Resistance		

History of Destruction of Property?

History of Physical Aggression (if yes, please explain)

Stability – History & Current Concerns:

Medication:

	Medication Name	Date of Initiation	Intended Use	Compliance (Y/N)
1.				
2.				
3.				
4.				
5.				
6.				

History of Discontinued Medication & Rational Behind Discontinuation: