420 East Sarnia Street
Winona, MN 55987

info@hvmhc.org
www.hvmhc.org

Children's Therapeutic Services and Supports (CTSS)
Referral Form

CTSS is a flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. CTSS addresses the conditions of emotional disturbance that impair and interfere with an individual's ability to function independently. For children with emotional disturbances, rehabilitation means that services are provided to restore the child to a level of functioning that they either had or would have achieved if normal development had not been impaired by a mental health disorder. CTSS services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach measurable treatment outcomes identified in an individual treatment plan (ITP).

Please fill in as much information that you have available. **Please do not hesitate to make a referral because you do not know all of this information as we will work on our end to gather missing information.**

Please provide some narrative as to what you the referral source believe are needed services, and what the family has expressed as needed to assist them.

_____

Referring Agency: _____ Worker: _____ Phone #: _____
Child's Name: _____ Date of Birth: _____
Age: _____ ☐M ☐F SS #: _____

Client has Medical Assistance/PMAP: ☐ YES ☐ NO, If yes, PMI # _____
Date and Place of Last Placement and or Hospitalization _____
Diagnosis _____
Psychiatrist/Medical Doctor _____
Medications _____

Involved Agencies:
Probation/Truancy: _____

County Child Protection: _____

Special Education/School Attending: _____

Other: _____

Parent/Guardian Name: _____ Phone: _____
Address: _____ City: _____
Zip: _____ County:_____

** CTSS understanding: the family is only contacted by HVMHC if the ***referring agency person*** has briefly explained to the family that this service is available, and that the family acknowledges wanting a provider from Hiawatha Valley Mental Health Center (HVMHC) to contact them to further explain service options.

I AUTHORIZE FOR THE REFERRAL SOURCE AND HVMHC STAFF TO COMMUNICATE WITH EACH OTHER REGARDING THE STATUS OF THIS REFERRAL ONLY.

Signature of referral source: _____ Date: _____

If you have questions or a family has questions about CTSS,
please call Sally Poepping at (507) 961-9407.

Please return this form to:
Sally Poepping
Hiawatha Valley Mental Health Center
420 East Sarnia Street
Winona, MN 55987
Fax: (507) 474-9471
SallyP@hvmhc.org