



Barron County Coordinated Services Team (CST) Referral Form

Name of Child (include middle initial): _____

Date of Birth: _____ Age: _____ SSN: _____

Address: _____

Caregiver/Parent(s) Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

Relationship to Child: _____

Referral Person/Title: _____ Referral Date: _____

Phone Number: _____ Fax #: _____

Reason for Referral: _____

Funding source:

MA SSI Katie Beckett Private Insurance Parents Other _____

Please check all that apply:

Use of multiple direct services (e.g. mental health, special education, juvenile justice, child protective services, alcohol and other drug services)

Child has a severe emotional disability/mental health diagnosis: _____

Other interventions have not been successful over time or persistent obstacles to service access and/or need for service coordination exists

At risk of out of home/institutional placement

Parents are willing to be involved in the team process

List other significant people in the child/family's life (please include age and relationship):

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

