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|  | **Referral/Authorization for ECLIPSE Services** |

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| **SECTION 1 - REFERRAL** |
| 1. ECLIPSE CONTRACTED PROVIDER | 2. PROVIDER SITE | 3. PROVIDER NUMBER |
| 4. PROVIDER ADDRESS |
| 5. ECLIPSE FACILITY/ CONTACT PERSON | 6. TELEPHONE NUMBER |
| 7. CHILD’S NAME | 8. CASE NUMBER | 9. DATE OF BIRTH |
|  **SECTION 2 – AUTHORIZATION OF SERVICES**   |
| **[ ]**  **Initial Referral Authorization** | **[ ]**  **Re-Authorization** | **[ ]**  **Program Discharge/Withdrawal**  |
| 1. REFERENTS NAME | 2. EMAIL ADDRESS | 3. REFERRAL DATE      | 4. CURRENT DCYF SAFETY PLAN? **[ ]**  Yes **[ ]**  No |
| 5. OFFICE/BRANCH | 6. ORGANIZATION**[ ]**  CW **[ ]**  ESA **[ ]**  PH  | 7. TELEPHONE NUMBER |
| **SECTION 3 – DEPARTMENT of CHILDREN YOUTH and FAMILIES ONLY**  |
| ECLIPSE ADMINISTRATOR  |  DATE |
| AUTHORIZATION DATES: **(Should be no longer than 6 months)** | BEGIN:  | END:  |

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| **REFERRAL/AUTHORIZATION OF SERVICES INSTRUCTIONS**This form acts as an Initial Program Referral, Re-authorization, and Discharge of ECLIPSE Program Services for each child enrolled in the ECLIPSE Program. The form is to be completed by ECLIPSE referral source staff including: Child Welfare Division of Department of Children, Youth, and Families (DCYF) Social Workers, Public Health Nurses, and Economic Services Social Workers. The following instructions provide guidance to referent on how to complete referral/authorization of services form. **SECTION 1 - REFERRAL**This section is to be filled out by the referent to include the following information regarding the child referred and ECLIPSE Provider: 1. Name of ECLIPSE Contracted Provider. 2. Name of ECLIPSE program site. 3. ECLIPSE provider number. 4. ECLIPSE address. 5. Name of ECLIPSE facility contact person. 6. Telephone number of ECLIPSE contact person. 7. Child’s name. 8. Child’s case number.  9. Child ‘s date of birth.**SECTION 2 - AUTHORIZATION OF SERVICES \*\* SAFETY PLAN\*\***This section is to be filled out by the referent. Be sure to indicate within this section the correct service provision being requested as per the child’s circumstance*.*  If a safety plan is in place at the time of child’s referral/reauthorization referent will indicate yes in box # 4. ECLIPSE Provider will request that referent **send a copy of the plan** to **ECLIPSE Program** upon authorization to ensure planning can occur before child begins. **Proper Consents needs to be exchanged as per Provider/Referent Arrangement.****Initial Authorization**:If this is the first time referring child to ECLIPSE the purpose would be to initiate services, the referent would check the Initial Referral Authorization box.Program services include:* Strength-Based Clinical Assessment and Age Appropriate Treatment Services
* Quality Early Learning Care in State Licensed Facilities that focus on Children’s Social/Emotional Wellness
* Monthly Home Visits with family to assist families with developing family goals and outcomes

 ECLIPSE Provider Staff will send quarterly progress reports to referral sources (when requested) that will include:* Summary of monthly home visits
* Status of child’s progress in reference to services received to support treatment outcomes
* Families participation, progress, and completed family goals and outcomes
* Update on safety issues regarding (safety plan) if applicable.

**Re-Authorization**:If a child is attending the ECLIPSE program and requires continued attendance ECLIPSE provider staff will notify the referent. Services can be reauthorized for up to 6 months referent will need to check Re-Authorization box and email form to their agency contact person/email. The decision to reauthorize a child will be made during the multi-disciplinary team meeting (MDT) that occurs every 90 days. The MDT team is comprised of child’s parent/guardian, ECLIPSE provider staff, referent, and other professionals as needed. The purpose of the MDT is to collectively develop, update, and discuss child’s treatment plan goals and progress. ECLIPSE provider will invite referent to the MDT. **Program Discharge/Withdrawal**:MDT team will discuss/decide if program discharge is the case outcome and within the best interest of the child/family; ECLIPSE provider will check the Program Discharge/Withdrawal box on the referral form, email a copy to the ECLIPSE Administrator, notify the MDT team including the referent, and complete the families discharge plan with family. **SECTION 3 – DEPARTMENT of CHILDREN YOUTH and FAMILIES ONLY**This section will be completed by the ECLIPSE Administrator; gatekeeper for the financial authorization of children to the program and provider payment. The gatekeeper will sign, date and authorize the dates of service on the referral form. |
| **AGENCY CONTACTS TO ASSIST EXPEDITE ECLIPSE REFERRAL/AUTHORIZATIONS:**Once referent completes the referral form, it is to be sent to one of the Agency Contacts. Respective agency contact will send referral to the ECLIPSE Administrator for authorization. Child’s Referral/Re-Authorization will be scanned to the ECLIPSE Provider. Provider will obtain child’s primary caregiver contact information and begin the enrollment process.ECLIPSE Administrator will send a copy of the child’s completed authorization to the referent and agency contact person for the record. Each Agency Contact Information is listed below by email.**State Agency Contacts:****Department of Children Youth and Families/Child Welfare: Social Workers shall send all ECLIPSE referrals and reauthorization to: Secure email to veronica.santangelo@dcyf.wa.gov** **email:** ECLIPSEreferral@dcyf.wa.gov**Economic Services Administration: Social Workers shall send all ECLIPSE referral and reauthorization to:** **email:** dcyf.esaeclipsereferrals@dcyf.wa.gov**Public Health Administration:****King County Public Health: Public Health Nurses shall send all referrals and reauthorizations to:** **Secure email-** **Veronica.santangelo@dcyf.wa.gov** **With a cc to Rebecca Benson email-** **Rebecca.benson@kingcounty.gov****Maternal Health Services: Public Health Nurses working with Memorial’s Maternal Child Health Services shall send all referrals and reauthorizations to:**  **Secure email-** **Veronica.santangelo@dcyf.wa.gov****Yakima Valley Farm Workers Clinic Community Health Services: Public Health Nurses working with Yakima Valley Farm Workers Clinic Community Health Services shall send all referrals and reauthorizations to:** **Secure email-** **Veronica.santangelo@dcyf.wa.gov****Yakima Neighborhood Health Services: Public Health Nurses working with Yakima Neighborhood Services shall send all ECLIPSE referrals and reauthorizations to:** **Secure email-** **Veronica.santangelo@dcyf.wa.gov****ECLIPSE Administrator: FYI, please do not hesitate to send any questions you may have.** **Veronica Santangelo** **veronica.santangelo@dcyf.wa.gov** |