REFERRAL FORM

Date: _____

Referral by:_____ **Agency/Organization**:_____

Phone: _____ **Email:** _____

Youth's Name:	Date of Birth:	Race:	Gender/Identification:

Reason for Referral: (check all that apply)

☐ Developmental Disability	☐ Substance/Alcohol Abuse	☐ Early Intervention
☐ Child Neglect	☐ Poverty	☐ Delinquent
☐ Medical	☐ Behavior Problems	☐ Abandonment
☐ Family Conflict	☐ Legal Issues/Incarceration	☐ Physical Abuse
☐ Poor Social Skills	☐ Suicidal Ideation	☐ Mental Health
☐ Special Education	☐ Child Abuse	☐ Physical Health Concerns
☐ Autism Spectrum Disorder	☐ Aggression/Assault	☐ Death of parent/guardian
☐ Stealing	☐ Runaway	☐ Sexual Abuse
☐ Cruelty to Animals	☐ Problem Sexual Behavior	☐ Hyperactivity
☐ Sleep disturbance	☐ Destruction of Property	☐ Experienced Developmental Trauma

Custody: ☐ Adopted Parent(s) ☐ Biological Parent(s) ☐ Legal Custody of Family Member
☐ Children Services ☐ Temporary Custody of Family Member

Parent/Guardian Name:	Parent/Guardian Name:
Relationship: Marital Status: Date of Birth:	Relationship: Marital Status: Date of Birth:
Address:	Address:
City: State:	City: State:
Zip: Home Phone:	Zip: Home Phone:
Employer:	Employer:
Work phone: Cell phone:	Work phone: Cell phone:
Email:	Email:

Other household members:	DOB:	Relationship to Youth:

INSURANCE:

Type of Insurance (youth):	☐ Medicaid	☐ Private Insurance	☐ No Insurance
	☐ Buckeye CHP		
	☐ CareSource		
	☐ Molina		
	☐ Paramount Advantage		
	☐ United Healthcare		

Is the youth/child out of the home currently (hospital, detention, treatment, residential facility)?

☐ Yes If yes, please enter date placed: _____
☐ No

If yes complete the following:

Placement:			Contact:
Address:			Phone:
City:	Zip:	State:	Email:

Is the child currently at-risk for out-of-home placement?

☐ Yes
☐ No
If yes, please explain:
_____
_____
_____

SUPPORTS:

PROFESSIONAL SUPPORTS Name of Contact	**Contact Info-Name, Phone # Agency Name**	**Email Address**
Children Services		
Juvenile Court		
Mental Health Provider		
Substance Abuse Treatment Provider		
Huron County Department of Developmental Disabilities		

Department of Youth Services		
School		

NATURAL SUPPORTS (family, mentors, close friends, etc.)			
Name of Contact:	**Relationship:**	**Phone:**	**Email Address (if known):**

Additional Information

1. Is the Youth/Child currently enrolled in school?
   - ☐ Yes Name of School: _____ Homeschooled: ☐
   - ☐ No

2. Does the Youth/Child have an IEP?
   - ☐ Yes
   - ☐ No Grade Level _____

3. Does the Youth/Child have a Mental Health Diagnosis?
   - ☐ Yes Date of Diagnosis: _____ Diagnosed By: _____
   - ☐ No

MENTAL HEALTH DIAGNOSIS:

☐ ADD/ADHD	☐ Mood D/O	☐ PTSD	☐ Disruptive Mood Dysregulation D/O
☐ Depression	☐ Conduct D/O	☐ Psychosis	☐ Other (list below):
☐ Attachment D/O	☐ Oppositional Defiant D/O	☐ Schizophrenia	
☐ Bipolar D/O	☐ Obsessive Compulsive D/O	☐ Eating D/O	

DD DIAGNOSIS:

☐ Severity Unknown	☐ Mild (IQ 55-69)	☐ Moderate (IQ 41-55)	☐ Severe (IQ 27-41)
☐ Autism Spectrum	☐ Other Developmental Disability		
DX: (Please list)			

4. Is an assessment scheduled?
   - ☐ Yes When: _____ Where: _____
   - ☐ No

5. Does the Youth/Child have pending charges in Juvenile Court?
   - ☐ Yes
   - ☐ No
6. Are there currently safety concerns for the youth or family members?
   - ☐ Yes
   - ☐ No

   If so, please explain:

   _____

   _____

7. What is the intended service, as recommended by the referring agency?
   - ☐ Service Coordination (youth-focused, individually based)
   - ☐ High Fidelity Wraparound (family-focused, more intensive cases)

IN WHAT WAYS WOULD FCFC SERVICE COORDINATION BENEFIT THIS FAMILY?

WHAT ARE THE STRENGTHS OF THIS FAMILY?

8. Have there been other interventions/providers involved other than those listed above? If yes, please list/explain:_____

   _____

9. **PLACEMENT HISTORY: Please attach documentation related to placement history, when & where (hospitalizations, residential, foster care, DYS, DH).**

***A referral will not be accepted without a completed Release of Information signed by the legal guardian of the youth being referred.**

Send completed forms to:

Family & Children First Council of Huron County

Family and Children First Council of Huron County
Attn: Niki Cross, Director
Nicole.Cross@jfs.ohio.gov
185 Shady Lane Drive
Norwalk, OH 44857
(419) 668-8126 ext. 3336
Fax: (419) 668-4738