Family & Children First Council of Huron County

REFERRAL FORM

Date: _______________

Referral by:_____________________________________ **Agency/Organization**:_______________________________

Phone: _____________________________________ **Email:** ____

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

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 current safety concerns for the youth or family members?
   - ☐ Yes
   - ☐ No

   If so, please explain:

   ____

   ____

7. Has the youth had a CANS (Child & Adolescent Needs & Strengths) Assessment completed within the last 30 days?

   ☐ Yes ☐ No ☐ Not Sure

8. Has the youth been referred to Harbor for OhioRISE eligibility?

   ☐ Yes ☐ No ☐ Not Sure

9. Has the youth been referred to the Mobile Response Stabilization Service (MRSS) program?

   ☐ Yes ☐ No ☐ Not Sure

IN WHAT WAYS WOULD FCFC SERVICE COORDINATION BENEFIT THIS FAMILY?

WHAT ARE THE STRENGTHS OF THIS FAMILY?

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

    ____

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

Send completed forms to: Family and Children First Council of Huron County

Attn: Niki Cross, Director
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