HCFCFC REFERRAL FORM

Date: _____

Referred By:_____ **Agency/Relationship**:_____

Phone: _____ **Email:** _____

Youth's Name:	**Date of Birth:**	**Race:**	**Gender/Identification:**
Youth SS#:	**Youth SSID (school ID):**		

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: _____ Location: _____
☐ 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 If so, by who? _____

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: HCFCFC-Referrals@jfs.ohio.gov or via mail/drop off:

Family & Children First Council of Huron County

Huron County FCFC
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Norwalk, OH 44857
(419) 668-8126 ext. 3336 Fax: (419) 668-4738