

HANCOCK COUNTY FAMILY & CHILDREN FIRST COUNCIL REFERRAL

A. REFERRAL INFORMATION

Date of Referral:	Agency/Relationship to Youth:
Name of Person Making Referral:	Phone Number:
Address:	City:
State:	Zip Code:

Type of Referral:

Service Coordination
 Wraparound

B. CHILD/ YOUTH DEMOGRAPHICS

Name of Youth:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Race/Ethnicity:
Currently Living with: (Name)	Relationship to child:
Address:	City/State/Zip Code:
Phone:	Alternate Phone:
Caregiver #1 Employer (Business, Address, Phone):	Caregiver #2 Employer (Business, Address, Phone)
Who has Custody of Youth/Relationship to Youth:	Custodian Contact Information:
Who is Youth's Guardian/Relationship to Youth:	Guardian Contact Information:
Caregiver #1 Employer (Business, Address, Phone)	Caregiver # 2 Employer (Business, Address, Phone)
School District of Residence:	School District of Attendance:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:

Describe Youth's/Family's Church Affiliation:

Primary Physician at Time of Intake? Yes No

If Yes:
 Physician Name _____ Phone No. _____
 Address _____
 Medicaid or Medicaid Managed Care Plan? If so, provider name _____

C. SERVICE COORDINATION INFORMATION

1. Who is the Service Coordinator (lead contact person for the youth/family)?

Name: _____ Agency: _____ Phone: _____

2. Best time/method to meet/reach youth/family?

3. What is youth's/family's preferred meeting place?

4. What agencies are currently involved with the youth/family? Please check all that apply.

<u>Name of Agency</u>	<u>Contact Person</u>	<u>Date of Last Appointment</u>
<input type="checkbox"/> HC Child Protective Services		
<input type="checkbox"/> Family Resource Center		
<input type="checkbox"/> Other Mental Health Provider:		
<input type="checkbox"/> Hancock County Board of DD (BVC)		
<input type="checkbox"/> Probation/Parole/Juvenile Court		
<input type="checkbox"/> HC Family Court with this program		
<input type="checkbox"/> School (IEP/504/GRADS/Counseling)		
<input type="checkbox"/> HC DJFS (SSI, Food Stamps, Medicaid)		
<input type="checkbox"/> County/City Health Dept.		
<input type="checkbox"/> HMG/Early Intervention		
<input type="checkbox"/> HMG/Home Visiting		
<input type="checkbox"/> WIC		
<input type="checkbox"/> Metro Housing		
<input type="checkbox"/> Psych./Hospitalization		
<input type="checkbox"/> CASA		
<input type="checkbox"/> Keeping Kids Safe		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		

D. PRESENTING NEEDS

1. Briefly describe the presenting issue or areas of need (include length of time the issue has been occurring).

2. Explain what community resources have been exhausted to ensure least restrictive service implementation. Please indicate what services have been provided and by what agencies. Also indicate what financial resources have been exhausted to provide services/needed items.

Community:

Financial:

3. What barriers have the youth/family encountered that has prevented previous/current services to not be successful?

4. Identify the end goal or mission of the Youth/Family and agencies involved (this must be a measurable goal).

5. Does the Youth/Family feel they will be able to fulfill the necessary commitments to achieve the end goal or mission? Why or why not? If not, what can we do to help them make this commitment?

I participated in the referral process, agree with it and the information provided therein, and understand my family's commitment.

Parent/Guardian Signature

Date

FCFC USE ONLY

Person receiving referral:

Date:

Risk Assessment Score: _____
 Are IHBT services being provided?
 Yes
 No

Did youth score any "3"
 Yes
 No
 If yes date of meeting:

Outcome of referral:

Information & Referral Service Coordination Wraparound

Service Provider/Agency Assigned Case:

Date:

FCFC Coordinator Signature:

Date: