FAMILY WRAPAROUND REFERRAL FORM

Intake Person: _____ Date of Referral: _____

Please complete ALL fields – Please provide as much information as possible

Person Making Referral		**Phone #**
Referral Agency:		
Are you partnering with another agency in making this referral? Yes_____ No _____ **If "YES" please list the agency or agencies partnering in making this referral:**		
How was the family notified/informed about Wraparound? (Families MUST be notified prior to submitting a referral)		

GENERAL INFORMATION

Name of Youth		**Date of Birth**	
Address		**Age**	
City, State, Zip		**Gender**	
Cell Phone #		**Medical Insurance**	
Ethnicity		**Language Preference**	
Mother's Name		**Father's Name**	
Address		**Address**	
City, State, Zip		**City, State, Zip**	
Phone #		**Phone #**	
Mother's ethnicity		**Father's ethnicity**	

EDUCATION STATUS of YOUTH

Current Grade	**Current School:**
School Address:	**School Phone:**
IEP: Yes No	**Date of most current IEP:**
504 Plan: Yes No	
School Concerns or Specific Interventions at School:	

SIBLINGS

Name	Age/Ethnicity	Residence / Living with

SIGNIFICANT SUPPORTS in YOUTH'S LIFE

Name	Relation	Contact # / Address

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NEEDS

	P	C		P	C		P	C
Homelessness			Divorce			Domestic Abuse / Violence		
Financial needs			Arrest/Incarceration of a parent			Drug/Alcohol Abuse		
Parenting needs			Parent/caregiver deployed			Addictions		
Mentoring for prevention			Death of a family member			Lack of social support		
Education issues			Frequent moves			Loss of a friend		
Delinquency			Frequent family fighting			DD or Physical impairment		
DJFS involvement			Lower level sex offense			Bullying		
Removal from birth family			Higher level Sex offense			Criminal activity		
Separation from siblings			History of Running away			Physical Abuse		
Out of home placement			Physical Abuse			Sexual Abuse		
Medical hospitalization			Neglect			Neglect		
Psychiatric hospitalization			Traumatic event (fire, accident, etc.)			Advocacy – schools, DD agencies,		
Self-injurious behaviors			**Y = Youth F = Family**			**P=Past C=Current**		

AGENCY INVOLVEMANT

Agency	Family Member	P = Past / C= Current	Provider / Worker Name & Number

ASHLAND COUNTY CHILDREN'S SERVICES/JUVENILE COURT INVOLVEMENT

Caseworker/Juvenile Probation Officer Name & Phone #:
Current Interventions:

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REASON FOR REFERRAL

Reason being Referred:

Family Goals for Program:

Goal #1:_____

_____

_____

Goal #2:_____

_____

_____

Goal #3:_____

_____

_____

Additional Goals:_____

_____

_____