**Service Coordination Referral Form**

Please ensure that an ACFCFC Release of Information is attached to this form. As well as it is understood that the youth has unmet needs in two or more of the identified service systems and is at risk of out of home placement.

|  |  |  |
| --- | --- | --- |
| First Name | Last Name | Social Security Number |
| Date of Birth | Preferred Language | Gender |
| Race: [ ] American Indian/ Alaskan Native [ ] Asian [ ] Black or African American [ ] Hispanic/ Latino [ ] Pacific Islander [ ] White/ Caucasian [ ] Mixed race [ ] Other [ ] Declined to Specify |
| Youth Street Address: |
| City | State | Zip Code |
| Youth Phone Number |

Youth Information

Caregiver Information \*\*Please include any current custody order\*\*

|  |  |
| --- | --- |
| Name | Name |
| Phone Number | Phone Number |
| Relationship to Youth | Relationship to Youth |

Caregiver 1: [ ] Primary Contact Caregiver 2: [ ] Primary Contact

Additional Family Members

This could include any member of the family outside of the home that may be a support to the family but must include all individuals living in the home.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Household Member | Date of Birth | Relationship to Youth | Household Member |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |
|  |  |  |  [ ] Y [ ] N |

Referral Source

|  |  |  |
| --- | --- | --- |
| Name | Agency | Date of Referral |
| Phone Number | Email |

|  |  |  |
| --- | --- | --- |
| District Responsible | Grade | Current School |
| [ ] IEP, ETR, 504 or Special Education | [ ] Youth is at risk of failing current grade |
| [ ] Attendance Problems | [ ] Behavior Infractions |
| [ ] Alternate School | [ ] Other Services or Therapies Provided at School |

 Education or School [ ] Identified Need

|  |  |  |
| --- | --- | --- |
| Agency | Provider | Diagnosis |
| List all current medications.  |
| Psychiatrist: | Therapist/ Counselor | Case Manager |
| Multi-Systemic Provider (MST) | Other |

 Mental Health [ ] Identified Need

|  |
| --- |
| SUD Program/ Treatment Agency Name |
| Date of Last SUD Assessment | Clinician/ Program Assessment was completed with |

 Substance Use Disorder or Treatment [ ] Identified Need

|  |
| --- |
| \*\* Attach any current court orders to referral\*\* |
| [ ] Pending Charges  | [ ] Current Orders |
| [ ] Unruly Youth | [ ] Delinquent Youth |
| [ ] Diversion | [ ] Probation |
| [ ] Registered Sex Offender | [ ] Other |
| Please Explain any marked above.  |

 Juvenile Justice [ ] Identified Need

|  |  |
| --- | --- |
| [ ] Current Investigation | [ ] Kinship Services |
| [ ] Current Case Plan | Case Worker Name: |
| [ ] Previous Removal of Custody | [ ] Other |

 Children Services Board [ ] Identified Need

|  |  |  |
| --- | --- | --- |
| Evaluation Completed[ ] Yes [ ] No | Date Completed | Outcome |
| SSA Name | Waiver in Place[ ] Yes [ ] No [ ] Pending | Waiver Type |

 Developmental Disability [ ] Identified Need

|  |  |
| --- | --- |
| [ ] Medicaid  | [ ] Food Stamps |
| [ ] Ohio Works First (OWF) | [ ] SSI or Disability |
| [ ] Other |

 Job and Family Services or Financial Benefits [ ] Identified Need

|  |  |
| --- | --- |
| Primary Care Physician | Date of last physical |
| Diagnoses | Other Medical Concerns | Current Medications |

 Healthcare or Physical Health [ ] Identified Need

|  |  |
| --- | --- |
| [ ] Early intervention | EISC and/or DS Name: |
| [ ] Head Start | Location: |

 Early Childhood Services [ ] Identified Need

|  |  |  |
| --- | --- | --- |
| Service / Provider | Start / End of Service | Helpful? |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |
|  |  | [ ] Y [ ] N |

 Other [ ] Identified Need

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Reason for Referral

|  |  |
| --- | --- |
| Youth: | Household: |
| [ ] Issues at home with family | [ ] Unemployment | [ ] Loss/ Denial of Benefits |
| [ ] Financial Problems | [ ] Access to Care / Medicine | [ ] Physical Mental Health  |
| [ ] Suicidal/ Severely Withdrawn | [ ] Substance Use in the home | [ ] Domestic Violence |
| [ ] Problems with Peers | [ ] Availability of Weapons | [ ] Housing (loss or unsafe) |
| [ ] Problems with Authority | [ ] Utilities not working | [ ] transportation |
| [ ] Verbal/ Physical Aggression | [ ] Lack of food or clothing | [ ] Hygiene of individuals |
| [ ] Behavior Management | [ ] Other |
| [ ] Hygiene |

\*\* In your own words, please describe why Service Coordination is needed for this youth or any challenges the family may be experiencing. Please be detailed with concerns of identified needs in this section. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |
| Signatures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Youth Name (Printed) Youth Signature Date\*\* If developmentally appropriate\*\* |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Caregiver 1 Name (Printed) Caregiver 1 Signature Date |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Caregiver 2 Name (Printed) Caregiver 2 Signature Date |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Referral Name ( Printed) Referral Signature Date |  |
|  |  |

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*FOR FCFC USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

|  |  |  |
| --- | --- | --- |
| Date Received | Date Reviewed | Reviewed By |
| [ ] Does not meet Criteria [ ] Community Information [ ] Other [ ] Cross- System Team Service Coordination [ ] Case Consultation [ ] Comprehensive Family Support Team Service Coordination |
| Additional Information about decision: |
| Assigned To: | Referral Source Notified | Reviewer Signature |