Wraparound Family Partner REFERRAL FORM

in BRIEF

Briefs are provided as a best practice reference or topic example to support communities in developing the family partner role.

CFP ELIGIBILITY CRITERIA:

Wraparound Family Partner

- ☐ Flexible
- ☐ DD System Involvement
- ☐ Cross over youth JJ/DHS

SECTION I: To be completed by *referring party*

1. Child/youth name: ____
Last First MI

2. Child/youth Date of Birth: ____________________ **Age:**_____ **Male:**___ **Female:**___ **Transgender:**___ **Other:**___

3. Is the child/youth of Hispanic or Latino cultural/ethnic background? ☐ Yes ☐ No

If YES: Which group describes his/her Hispanic or Latino cultural/ethnic background?
☐ Mexican, Mexican-American, or Chicano ☐ Central American ☐ Puerto Rican
☐ South American ☐ Cuban ☐ Dominican
☐ Other Hispanic origin - specify ____________________

4. Which best describes the child? Is he/she… *(select all that apply)*
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Other please specify: ______________________

5. What school does the child/youth attend? ____

6. Placement at time of referral (check all that apply):
☐ Home ☐ Residential ☐ Psychiatric Hospital ☐ Detention ☐ Other:____________
☐ Foster Care ☐ Guardian Placement

Address of child/youth residence at time of referral:

____ Zip code: ___________

Phone number of child's residence at time of referral: ____

7. **Name of legal guardian or responsible party**: ____

Address: ____ Zip Code:__________

Relationship to Child/youth: ______________________________ Phone: ______________________

Legal Guardian's email address: ____

8. **Indicate the systems that the child/youth is presently receiving supports:**

☐ Juvenile Justice

Juvenile Counselor: ______________________________ Phone: ______________________

☐ DHS (Child Welfare):

DHS Worker: ______________________________ Phone: ______________________

☐ Mental Health

Therapist & Agency: ______________________________ Phone: ______________________

Psychiatrist & Agency: ______________________________ Phone: ______________________

☐ Education (☐Special Education ☐504 Behavioral Plan) Other: ______________________________

School Contact & Role: ______________________________ Phone: ______________________

☐ Medical: ☐ Child is healthy: Yes No (Circle one)

☐ Child has an ongoing medical condition requiring coordination (diabetes, cancer, severe asthma, etc.)

Describe Condition: ____

Coordinating Physician/Specialist: ______________________________ Phone: ______________________

☐ Other Community/Natural Supports

Type: ______________________________ Phone: ______________________

Type: ______________________________ Phone: ______________________

10. **Primary language spoken in children's home:** ____________________ **interpreter needed?** ☐ Yes ☐No

11. **Please select all the Wraparound life domains that need/may need further support from FP:**

☐ Family Relationships ☐ Home/A place to Live ☐ Psychological/Emotional
☐ Educational Vocational ☐ Social/Recreational ☐ Spiritual/Cultural
☐ Legal ☐ Health/Medical ☐ Substance Abuse/ Addictions
☐ Daily Living ☐ Crisis/Safety ☐ Financial
☐ Other: ______________________

12. **Further clarify how the family partner will support the life domain that was selected above:**

____
____
____
____
____
____

13. List presenting crises and safety issues:

____
____
____
____

14. Additional reasons for referral: Please provide specific behaviors/emotional needs & strengths of the child and family.

____
____
____
____

15. Specific cultural/linguistic needs: (Cultural Connections & Resources, Gender Specific, Hearing/Vision, Other)

____
____
____
____

Name of person initiating FP referral: ______________________________ Organization: ________________________
Source of referral: ☐ Juvenile Justice ☐ DHS ☐ MH Provider ☐ Foster Care ☐ DD ☐ Education
☐ Other: _________________ Phone number ______________________ Email___________________________________

Relationship to child/youth: ____________________________________ Date Referral submitted: __________________

SECTION IV: *To be completed by Peer Supervisor*

1. Date of when referral was received: ____

2. Date of when Referral was presented: ____

3. System of Care enrollment status:
☐ Child is receiving, or has received, a mental health service but is NOT eligible for a (Wraparound or Family Partner).

Explanation: ____

☐ Child/Youth referred to other mental health service: ____
☐ Child/Youth referred to other community resource: ____

4. Youth/Child approved to receive (select all that apply):
☐ Wraparound ☐ Family Partner ☐ Family Partner & Wraparound

5. Assigned Family Partner: ____