Meigs County Family and Children First Council
Referral Form for Service Coordination/Wraparound Services

PLEASE PRINT CLEARLY AND COMPLETE THOROUGHLY

Date of Referral _____Child's Name _____DOB _____

Age at time of referral _____ Sex _____ Race _____ Medicaid # _____

Address: _____ Is Youth in Foster Care? ☐Yes ☐No

REFERRING AGENCY INFORMATION

Name of Referring Agency _____

Contact Person _____ Contact Phone _____

Email _____

Parent/Guardian Consent (required) ☐ Yes (see attached consent form) ☐ No

Please note: The contact person from the agency making this referral will be identified as the Team Leader for the family by the Intersystem Coordinator. They will be expected to collaborate with the Coordinator for as long as the family continues to be enrolled in Service Coordination/Wraparound Services.

FAMILY INFORMATION

Primary Caregiver(s) Name _____

Relationship to Youth: _____

☐ Address Same as Youth, if not provide the correct address below:

Address _____

Home Phone _____ Cell Phone _____

Email Address _____

Additional Youth in the Home ☐ Yes ☐ No

Names, Ages, and Relationship to Referred Child:

Submit Completed Application to:
meigsfcfc@gmail.com OR 175 Race St. P.O. Box 191 Middleport, OH 45760, ATTN: Taylor Ward

REASON(S) FOR REFERRAL (check all that apply)

- ☐ The youth does not need service coordination but has a documented need for social/recreational activity or other support
- ☐ The services and supports that the youth are receiving and/or will receive need coordinated and aligned. A family team (compromised of service providers and natural family supports) is needed to develop a coordinated plan of care.
- ☐ Youth is at eminent risk of out-of-home placement for treatment. A family team (compromised of service providers and natural supports) is needed to provide intensive support and/or treatment funding.
- ☐ Youth is in out-of-home placement and needs funding assistance to maintain placement
- ☐ Youth is in the process of being discharged from out-of-home placement and needs support for transitioning back into the community.

BRIEFLY DESCRIBE CONCERNS AND CASE HISTORY:

DESCRIBE DESIRED RESULTS FROM PARTICIPATION OF THIS PROGRAM:

WHAT SERVICES/SUPPORTS HAVE BEEN UTILIZED TO DATE?

☐ Intensive Home- Based Treatment ☐ Case Management ☐ Respite
☐ Mental Health Counseling ☐ TANF/SSI/Medicaid Assistance
☐ Residential/In-Patient Treatment ☐ Other (please specify) _____
☐ Other (please specify) _____

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CURRENT SYSTEM INVOLVEMENT (within the last 30 days). CHECK ALL THAT APPLY:

☐ Juvenile Court
- Name of P.O. _____ Phone # _____

☐ Educational Concerns
- Name of teacher/staff/school_____

☐ EI or HMG
- Name of Caseworker_____ Phone # _____

☐ DD (Developmental Disabilities)
- Name of Caseworker_____ Phone # _____

☐ Children Services
- Name of Caseworker_____ Phone # _____

☐ Physician/Hospital
- Name of Physician/Hospital _____

☐ Job and Family Services
- Medicaid ☐
- SSI ☐
- SNAP ☐
- Other ☐ _____

☐ Mental Health Services
- Name of Caseworker, Agency, and Phone #
  - _____
  - _____
  - _____
  - _____

☐ Other
- Name/Role/Contact Information
  - _____
  - _____
  - _____
  - _____

Name of Person Completing this Form _____ Date: _____

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