

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

FAMILY WRAPAROUND REFERRAL FORM

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 INVOLVEMENT

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:

REASON FOR REFERRAL

Return to Advocates For Families– Youth Intervention Services Wraparound Team Fax: 877-277-3297

FAMILY WRAPAROUND REFERRAL FORM

Reason being Referred:

Family Goals for Program:

Goal #1:

Goal #2:

Goal #3:

Additional Goals:
