Ashtabula County Family & Children First Council
3914 C Court, Ashtabula, Ohio 44004
phone: 440-998-8178 / fax: 440-992-6828

Ashtabula County Family & Children First Council Referral Form

This form is to be completed **with** the identified youth and/or family being referred. All responses on this document should reflect **only** the **last 30 days** and should be the **thoughts and concerns of the identified youth and/or family**.

Primary Considerations

☐ Release of Information has been completed and attached. (Referrals submitted without a properly completed Release of Information are a violation of HIPAA/FERPA, and will NOT be considered.)
☐ Youth is actively engaged with a minimum of two service systems that are not meeting the needs of the youth/family.
☐ The family perceives that they are in crisis due to the needs, behaviors, etc. of the youth.
☐ Youth is at risk of being removed from the home, either voluntarily or involuntarily. The risk level is: ☐ Low ☐ Moderate ☐ High

Youth Demographics

First Name:		Last Name:
Date of Birth:	Preferred Language:	Gender:☐ male ☐ female ☐ transgender
Race: (check only one) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Mixed Race ☐ Other ☐ Declined to Specify		
Street Address:		
City:	State:	Zip Code:
Primary Phone Number:		Alternative Phone Number:
Custodian Name:		Relationship to Youth:
Custodian Name:		Relationship to Youth:
Custodian Contact Information (if different from above):		

*If Custodian(s) is/are not birth parent(s), attach current custody documentation.

Family & Household Demographics:

Full Name	Date of Birth	Relationship to Youth	Household Member?
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes
			Yes / No / Sometimes

School/Education	
District of Responsibility:	
Current School:	Current Grade:
Provide Supporting Documentation for Items Indicated Below	
☐ IEP, ETR, 504, or Special Education (Provide details):	
☐ Poor Grades	
☐ Attendance Problems/Truancy	
☐ Behavioral Infractions	
☐ Alternate School	
☐ Other Services/Therapies (List):	

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Healthcare/Medical
Primary Care Physician (Name, Agency):
Date of Last Physical:
☐ Medical Specialists (Name, Agency):
☐ Medical Concerns (Provide Supporting Documentation)
☐ Diagnoses (Date Diagnosed, Diagnosing & Treating Physicians):

Mental Health
☐ Mental Health Treatment (Attach Service History for Last 30 Days) Agency Name:
☐ Psychiatric Hospitalization (Attach Service History for Last 30 Days) Agency Name:
☐ AoD Program/Treatment (Attach Service History for Last 30 Days) Agency Name:
▪ Last MH/SUD Assessment:
▪ Date:
▪ Diagnosis:
▪ Clinician:
▪ Current Treatment Plan:
▪ Psychiatrist/Prescriber:
▪ Therapist/Counselor:
▪ Case Manager/CPST:
▪ Other:

Juvenile Court
☐ Pending Charges
☐ Current Orders
☐ Unruly Youth (if yes, Describe):
☐ Delinquent Youth (if yes, Describe):
☐ Probation (if yes, PO Name & Attach Copy of Plan):
☐ Diversion (if yes, DO Name & Attach Copy of Plan):
☐ Multi-Systemic Therapy "MST" (if yes, Provider Name & Attach Maintenance/Crisis Plan):
☐ Other

Children Services Board
☐ Pending Report
☐ Current Investigation
☐ Case Plan (if yes, Worker Name):
☐ Alternative Response (if yes, Worker Name):
☐ Other (please specify):

Developmental Disability
☐ Developmental Disability Services (Provide Current Case Plan)
▪ SSA Name:
▪ Waiver: In Place? ☐ Yes ☐ No ☐ Pending Waiver Type:
▪ Attach documentation of services provided with waiver funding.

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Financial Benefits
☐ Medicaid (If yes, provide Medicaid Number):
☐ Food Stamps
☐ Ohio Works First (OWF)
☐ SSI/Disability
☐ Other

Early Childhood Services
☐ Early Intervention (If yes, Developmental Specialist Name):
☐ Head Start

Health Department
☐ Any Involvement with the Health Department (If yes, Provide Supporting Documentation)

Any Other Services in Place			
Service/Provider	Arranged/Coordinated By	Helpful?	Discontinued? When? Why?
		Yes / No	
		Yes / No	
		Yes / No	

Reasons for Referral

☐ Issues at home/with family	☐ Involvement with the Legal System
☐ Academic/school problems	☐ Verbal/Physical Aggression
☐ Financial problems	☐ Emotional/Mental Health
☐ Suicidal/Severely Withdrawn	☐ Physical Health/Medical Issues
☐ Abuse/Neglect	☐ Behavior Management
☐ Problems with Peers	☐ Toileting/Hygiene
☐ Problems with Authority	☐ Other:

Family/Household Challenges & Concerns (Provide Further Information)

☐ Unemployment:
☐ Loss/Denial of Benefits:
☐ Access to Medical Care/Medicine:
☐ Physical Health Issues of Others in the Home:
☐ Mental Health Issues of Others:
☐ Drug/Alcohol/Tobacco Use in the Home:
☐ Domestic Violence:
☐ Availability of Weapons (Gun/Other):
☐ Other Safety Concerns:
☐ Housing (Foreclosure, Eviction, Etc.):
☐ Utilities (Heat, Electricity, Running Water):
☐ Environmental Safety (Mold, Structural Damage, Infestation, Animals):
☐ Transportation:
☐ Food/Clothing:
☐ Hygiene/Sanitation:
☐ Other:

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What do the family and identified youth state is their current greatest need?
What other needs do the family and identified youth state they have currently?

As a service provider to this family and youth, do you see other needs they have not identified? If yes, provide details.

Family Resources & Natural Supports	
Caregivers (Family, Friends, Etc.)	
Religious (Church, Youth Group)	
School/Cultural Activities	
Employment/Benefits	
Recreational (Sports, Scouting, 4-H, Etc.)	
Other	

What are strengths of the family and the identified youth?

What does the family expect/hope to gain from Service Coordination?

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Signatures

Youth (if developmentally appropriate)		
By signing below, I acknowledge that Service Coordination has been understandably explained to me, that I was an active participant in the completion of this form, and that I agree to actively participate if I am deemed to meet eligibility criteria.		
Name (Printed)	Signature	Date

Parent/Guardian		
By signing below, I acknowledge that Service Coordination has been understandably explained to me, that I was an active participant in the completion of this form, and that I agree to actively participate if my family is deemed to meet eligibility criteria.		
Name (Printed)	Signature	Date

Referring Staff/Professional/Service Provider			
By signing below, I affirm that I have explained Service Coordination to the youth and family named in this paperwork, that I was an active participant in the completion of this form, that this form is complete (including the attachment of any needed documents), and that I believe the youth and family named in this document to be suitable candidates for Service Coordination.			
Name (Printed)	Signature		Date
Agency	Phone Number	Email Address	

Service Coordination Team Representative		
By signing below, I affirm that I have reviewed this form for completeness (including the attachment of any needed documents), and that I believe the youth and family named in this document to be suitable candidates for Service Coordination.		
Name (Printed)	Signature	Date

**********************DO NOT WRITE BELOW THIS LINE**********************

Eligibility Evaluation
Date Received:
Date Reviewed:
Reviewed by:
Recommended Course of Action: ☐ Community Information ☐ Case Consultation ☐ Cross-System Team Service Coordination ☐ Comprehensive Family Support Team Service Coordination ☐ Other:
Additional Information/Explanation Regarding Referral Outcome:
Date Family Notified:
Date Referral Source Notified:
Reviewer Signature: