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| **REFFERAL INFORMATION** | | | | | | | | | | | | | | | |
| **I am submitting this ICC Referral to:**  *Referrals can be submitted to both providers to minimize amount of time youth/family wait to be assigned a facilitator.*  Wraparound Fairfax  UMFS/ICC | | | | | | | | **FSP Provider**  FSP is already working with the youth/family.  Provider: Click here to enter text. | | | | | | | |
| *Special requests for wraparound facilitator (e.g. Spanish speaking, etc.):* Click here to enter text. | | | | | | | | *Special request for family support partner (e.g. Spanish speaking, etc.):*  Click here to enter text. | | | | | | | |
| **YOUTH INFORMATION** | | | | | | | | | | | | | | | |
| Address: Click to enter address. | | | | | | | | | | | | | | | |
| City: Click to enter City. | State: Click to enter State. | | | ZIP: Click to enter ZIP. | | | | | Email *(if applicable)*: Click to enter text. | | | | | | |
| Race: Click to select item. | | | | | | | | | Hispanic Origin:  Yes  No | | | | | | |
| Youth’s current living situation:  Family |  Foster home |  Residential facility | Other (*please identify):* Click here to enter text. | | | | | | | | | | | | | | | |
| Educational Placement: | | | | | | | | | | | | | | | IEP:  Yes  No |
| Diagnosis (if known): | | | | | | | | | | | | | | | |
| Risk Factors Identified: | | | | | | | | | | | | | | | |
| **Reason for Referral** *(Please specify the needs to be addressed below (reference 2s and 3s on the CANS). Include services that have been previously utilized.)*  Click here to enter text. | | | | | | | | | | | | | | | |
| **Please check all that apply.**  **Out of Home Placement:**  Level C residential facility  Level B group home  Psychiatric hospitalization  Juvenile justice/incarceration placement  Regular foster home or if currently residing with biological family and due to behavioral problems is at risk for placement into DFS custody  Treatment foster care placement or if currently residing with a biological family or a regular foster family and due to behavioral problems is at risk of removal to a higher level of care  Emergency Shelter (when placement is due to child’s mental health/behavioral problems)  **At-Risk of Out-of-Home Placement:**  The youth currently has escalating behaviors that have put him/her or others at immediate risk of physical injury  Within the last 2-4 weeks the parent or legal guardian has been unable to manage the mental, behavioral, or emotional problems of the youth in the home and is actively seeking out-of-home care  One or more of the following services have been provided to the youth within the past 30 days and has not ameliorated the presenting issues:  Crisis Intervention  Outpatient Substance Abuse Services  Crisis Stabilization  Outpatient Psychotherapy  Mental Health Support  Day Treatment | | | | | | | | | | | | | | | |
| **FAMILY INFORMATION** | | | | | | | | | | | | | | | |
| Parent/Legal Guardian Name: Click to enter text. | | | | | | | | | | | | | | Phone: Click to enter phone. | |
| Address:  Check here if same as youth  Click to enter address. | | | | | | | | | | | | | | | |
| City: Click to enter City. | | State: Click to enter State. | | | ZIP: Click to enter ZIP. | | | | | | Email: Click to enter text. | | | | |
| Relationship to youth: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Parent/Legal Guardian name: Click to enter text. | | | | | | | | | | | | | | Phone: Click to enter text. | |
| Address: Check here if same as youth  Click to enter address. | | | | | | | | | | | | | | | |
| City: Click to enter City. | | State: Click to enter State. | | | ZIP: Click to enter ZIP. | | | | | | Email: Click here to enter text. | | | | |
| Relationship to youth: Click to enter text. | | | | | | | | | | | | | | | |
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| **Other/Additional Youth in the Home** | | | | | | | | | | | | | | | |
| Name: Click to enter name. | | | | | | | Age: Click to enter age. | | | | | Relation: Click to enter text. | | | |
| Name: Click to enter name. | | | | | | | Age: Click to enter age. | | | | | Relation: Click to enter text. | | | |
| Name: Click to enter name. | | | | | | | Age: Click to enter age. | | | | | Relation: Click to enter text. | | | |
|  | | | | | | | | | | | | | | | |
| Family’s Native Language: Click to enter text. | | | | | | | | | | | | | Interpreter Needed: Yes No | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | |
| Current CSA Copay on file: Yes No If yes, copay expires: Click to enter date. | | | | | | | | | | | | | | ***\*CSA Parental Contribution (Co-pay) agreement must be current prior to the start of services*** | |
| CSA Copay Waived: Yes No If yes, waiver expires: Click to enter date. | | | | | | | | | | | | | |
| Does youth/family have Medicaid:  Yes No | | | | | | | If no, is youth/family eligible for Medicaid:  Yes No | | | | | | | | |
| Does family have private insurance:  Yes No | | | | | | | If yes, insurance provider: | | | | | | | | |
| Other insurance information/notes: | | | | | | | | | | | | | | | |
| **AGENCY INVOLVEMENTS** | | | | | | | | | | | | | | | |
| Primary (Lead) CSA Case Manager/agency: Click to enter text. | | | | | | | | | | | | | | | |
| Phone: Click to enter phone. | | | FAX: Click to enter fax. | | | | | | | Email: Click to enter email. | | | | | |
| Past ICC involvement: Yes No If yes, which provider: UMFS Wraparound Fairfax | | | | | | | | | | | | | | | |
| Past FSP involvement: Yes No If yes, which provider: NAMI - FSP UMFS – FSP | | | | | | | | | | | | | | | |
| **OTHER AGENCY/PROVIDER INVOLEMENTS** | | | | | | | | | | | | | | | |
| Name/agency: Click to enter text. | | | | | | Email: Click to enter text. | | | | | | | | | |
| Phone: Click to enter phone. | | | | | | | | Fax: Click to enter fax. | |
| Name/agency: Click to enter text. | | | | | | Email: Click to enter text. | | | | | | | | | |
| Phone: Click to enter phone. | | | | | | | | Fax: Click to enter fax. | |
| Name/agency: Click to enter text. | | | | | | Email: Click to enter text. | | | | | | | | | |
| Phone: Click to enter phone. | | | | | | | | Fax: Click to enter fax. | |
| Name/agency: Click to enter text. | | | | | | Email: Click to enter text. | | | | | | | | | |
| Phone: Click to enter phone. | | | | | | | | Fax: Click to enter fax. | |
| Name/agency: Click to enter text. | | | | | | Email: Click to enter text. | | | | | | | | | |
| Phone: Click to enter phone. | | | | | | | | Fax: Click to enter fax. | |
| **CURRENT SERVICES PLACEMENTS *(REQUIRED)*** | | | | | | | | | | | | | | | |
| **If youth/family is receiving and is expected to continue receiving any of the following while receiving Family Support Partner Services, please check all that apply:**  Diagnostic/Evaluation/Assessment Services  Outpatient Services (including individual, group, family counseling, review/management of medications)  Crisis/Emergency Services  Intensive Home-based services  Intensive Day Treatment Services  Respite Care  Therapeutic Foster Care  Transition to Adult Services  Recovery Support Services such as Supported Employment  While waiting for other services to start  Other/Please name service: Click here to enter text. | | | | | | | | | | | | | | | |

**The referring Case Manager has provided the family with a brief introduction to the wraparound process to include the required participation expectations of the youth and family. The youth and family understand that this is an intensive planning process and have agreed to:**

* ***During Engagement Phase, participate in* w*eekly home visits with the wraparound   
  facilitator \_\_\_\_\_/\_\_\_\_\_\_*** *(Parent/legal guardian & youth’s initials)*
* ***Participate in monthly Youth and Family Team (YFT) meetings \_\_\_\_\_/\_\_\_\_\_\_*** *(Parent/legal guardian & youth’s initials)*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Youth signature*  *Date*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent/legal guardian signature Date*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent/legal guardian signature Date*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Case manager signature Date*

**Completed referral forms should be emailed to:**

UMFS: Jessica Grimes at [jgrimes@umfs.org](mailto:jgrimes@umfs.org)

Wraparound Fairfax: Doug Healey at [doug.healey@fairfaxcounty.gov](mailto:doug.healey@fairfaxcounty.gov)

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| **PROVIDER CONTACT INFORMATION**  *For questions regarding ICC/FSP providers, please contact the program supervisor:* | | |
| **Provider** | **Supervisor** | **Email** |
| Wraparound Fairfax | Doug Healey | [doug.healey@fairfaxcounty.gov](mailto:doug.healey@fairfaxcounty.gov) |
| UMFS-ICC | Courtnee Whitaker | [cwhitaker@umfs.org](mailto:cwhitaker@umfs.org) |

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