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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 | [x] 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 youthClick 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.  |
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| 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

Wraparound Fairfax: Doug Healey at 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  |
| UMFS-ICC | Courtnee Whitaker | cwhitaker@umfs.org  |

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