



SERVICE COORDINATION/WRAPAROUND REFERRAL

Youth Name:

School (if applicable):

Grade and/or Age:

Gender:

I am associated with this youth/family as follows:

Youth is involved with the following systems:

Mental/Behavioral Health

Board of Developmental Disabilities

Education

Child Protective Services

Juvenile Court

Other(s) _____

I feel that the following needs of the family can be addressed through service coordination/wraparound.

Mental/Behavioral Health

Poverty

Child Abuse

Child Neglect

Developmental Disability

Autism

Unruly

Delinquent

Alcohol/Drug Abuse

Special Education

Other(s) _____

I agree to meet with Service Coordinator/Wraparound Facilitator and family for informational meeting (approx. 1 hour). The best day(s)/time(s) for me and the family to meet are:

_____.

Comments:

Name/Organization:

Contact (Phone/email):

Return to: Peggy Grandbois, FCFC Coordinator, mfgrandbois@co.hancock.oh.us; 419-424-7073.