HANCOCK COUNTY FAMILY & CHILDREN FIRST COUNCIL REFERRAL

A. REFERRAL INFORMATION

Date of Referral:	Agency/Relationship to Youth:
Name of Person Making Referral:	Phone Number:
Address:	City:
State:	Zip Code:

Type of Referral:

☐ Service Coordination ☐ Wraparound

B. CHILD/ YOUTH DEMOGRAPHICS

Name of Youth:	Date of Birth:
Gender: ☐ Male ☐ Female ☐ Transgender	Race/Ethnicity:
Currently Living with: (Name)	Relationship to child:
Address:	City/State/Zip Code:
Phone:	Alternate Phone:
Caregiver #1 Employer (Business, Address, Phone):	Caregiver #2 Employer (Business, Address, Phone)
Who has Custody of Youth/Relationship to Youth:	Custodian Contact Information:
Who is Youth's Guardian/Relationship to Youth:	Guardian Contact Information:
Caregiver #1 Employer (Business, Address, Phone)	Caregiver # 2 Employer (Business, Address, Phone)
School District of Residence:	School District of Attendance:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:

Describe Youth's/Family's Church Affiliation:

Primary Physician at Time of Intake? ☐ Yes ☐ No

If Yes:

Physician Name _____ Phone No._____

Address _____

Medicaid or Medicaid Managed Care Plan? If so, provider name _____

C. SERVICE COORDINATION INFORMATION

1. Who is the Service Coordinator (lead contact person for the youth/family)?

Name: Agency: Phone:

2. Best time/method to meet/reach youth/family?

3. What is youth's/family's preferred meeting place?

4. What agencies are currently involved with the youth/family? Please check all that apply.

Name of Agency	Contact Person	Date of Last Appointment
☐ HC Child Protective Services		
☐ Family Resource Center		
☐ Other Mental Health Provider:		
☐ Hancock County Board of DD (BVC)		
☐ Probation/Parole/Juvenile Court		
☐ HC Family Court with this program		
☐ School (IEP/504/GRADS/Counseling)		
☐ HC DJFS (SSI, Food Stamps, Medicaid)		
☐ County/City Health Dept.		
☐ HMG/Early Intervention		
☐ HMG/Home Visiting		
☐ WIC		
☐ Metro Housing		
☐ Psych./Hospitalization		
☐ CASA		
☐ Keeping Kids Safe		
☐ Other:		
☐ Other:		
☐ Other:		

D. PRESENTING NEEDS

1. Briefly describe the presenting issue or areas of need (include length of time the issue has been occurring).

2. Explain what community resources have been exhausted to ensure least restrictive service implementation. Please indicate what services have been provided and by what agencies. Also indicate what financial resources have been exhausted to provide services/needed items.

Community: **Financial:**

3. What barriers have the youth/family encountered that has prevented previous/current services to not be successful?

4. Identify the end goal or mission of the Youth/Family and agencies involved (this must be a measurable goal).

5. Does the Youth/Family feel they will be able to fulfill the necessary commitments to achieve the end goal or mission? Why or why not? If not, what can we do to help them make this commitment?

I participated in the referral process, agree with it and the information provided therein, and understand my family's commitment.

_____ _____

Parent/Guardian Signature **Date**

FCFC USE ONLY

Person receiving referral:	Date:
Risk Assessment Score: _____ Are IHBT services being provided? ☐ Yes *(if yes, not eligible for WRAP)* ☐ No	Did youth score any "3" ☐ Yes ☐ No If yes date of meeting:
Outcome of referral: ☐ Information & Referral ☐ Service Coordination ☐ Wraparound	
Service Provider/Agency Assigned Case:	Date:
FCFC Coordinator Signature:	Date:

Hancock County Family and Children First Council
Cross System Risk Screen Tool

Family Name:	Date:
Child Name:	D.O.B.:
Service Coordinator: (Lead worker/contact):	Agency:

Known Presenting Risks to Child/Youth (in last 30 days unless specified):

☐ Suicidal Ideation, Gestures, Attempts (3 pts)	☐ Violent Behaviors (toward Others, Animals, Property) (3 pts)	☐ Chargeable for Sex Offense (3 pts)
☐ Self-Injurious Behavior (2 pts)	☐ Hears Voices/Sees Things (2 pts)	☐ Fire Setting Current or History (2 pts)
☐ Acute Family Crisis or Conflict (2 pts)	☐ Victimization: Physical, Emotional, or Sexual – Current or History (2 pts)	☐ Verbal/Written Threats to Others (2 pts)
☐ Runaway-Current (3 pts) or History (1 pt)	☐ Youth's/Family's Lack of Stable Residence/ Homelessness (2 pts)	☐ Suspected Abuse in Current Placement (2 pts)
☐ Availability of Weapons (2 pts)	☐ Parent w/Severe Chronic Illness (2 pts) Identify:	☐ Parent w/Drug or Alcohol Problem (2 pts)
☐ Aggressive Behaviors (toward Others, Animals, Property) (1 pt)	☐ Sexual Acting Out/ Impulsivity-Current (2 pts) or within Last Year (1 pt)	☐ Parent w/Chronic/Acute Mental Illness, Dev. Delay, MR (2 pts)
☐ Resides in High Crime Neighborhood (1 pt)	☐ Drug/Alcohol Use (1 pt)	☐ Lack of Caregiver Supervision and/or Monitoring (1 pt)
☐ Suspended, Expelled, Dropped out of School (1 pt)	☐ Negative Peer Involvement and/or Gang Activity (1pt)	☐ Anorexia/Bulimia (1 pt)
☐ Known/Suspected Criminal Activity (1 pt)	☐ Prejudicial Thinking/ Ideation (1 pt)	☐ Truancy (1 pt)
☐ Unrestricted Internet Access (1 pt)	☐ Impulsive Behavior (1 pt)	☐ Limited Ability to Control Anger (1 pt)
☐ Depression – Current or History (1 pt)	☐ Held Back/Behind in Grade Level within Last 2 Years (1 pt)	☐ IEP or 504 Plan in Place? (1 pt)
☐ Youth with Severe Chronic Illness (1pt) Identify:	☐ Youth with Chronic/Acute Mental Illness, Dev. Delay, MR (1 pt)	☐ Difficulty Accepting Supervision/Instruction (1 pt)
		☐ Other (describe) (1 pt)
Total Score:	Completed By:	
Information Source:		Relationship to Child/Youth:

Risk Screen Interpretation

Score of:	Results in following action:
Any 3 pt. item	An Emergency Service Coordination meeting will be held w/in 48 hours. Triage Representative will ensure a meeting occurs.
18+	Level #3 WRAP Facilitator is assigned (if openings are available) when informal case is requesting more support (2-system involvement required)
12-17	Level #2 Service Coordination. Service Coordinator will facilitate family team meetings/service coordination.
1 – 11	Level #1 Information & Referral Family will be linked up with existing services. A Service Coordination team is not indicated Individual will take normal action per their agency to continue providing services for the child, youth, and/or family.

Hancock County Family First Council
Authorization for Release/Exchange of Information

Family Name:_____

Children: _____ Date of Birth:_____
_____ Date of Birth:_____
_____ Date of Birth:_____
_____ Date of Birth:_____

Primary Agency:_____ Case Manager:_____

_____,being the Custodial Parent or the Legal Guardian or the Legal Representative of the Public Agency having custody of _____, born_____, a minor child, authorize the Member Agencies of the Hancock County Family First Council to release all service records of the above named child(ren)/family to the Hancock County Family First Council for the purpose of developing a coordinated plan.

I understand that these records are protected under Federal and State laws governing Confidentiality of Patient, Student, and Client Records, and cannot be disclosed or re-released without my written consent unless otherwise provided for the regulations.

I hereby release the Hancock County Family First Council from all legal responsibility or liability that may arise from this authorization.

The authorization may be revoked at any time, except to the extent that action has been taken in reliance thereon, by the notification of the Hancock County Family First Council of my intention to do so. This authorization (unless expressly revoked earlier) expires itself upon termination of the case.

Parent/Guardian Relationship Date

Signature of Witness Date

Agencies and Practitioners
Authorized to Release/Exchange Confidential Information

HANCOCK COUNTY AGENCIES/SERVICES:

___Family Resource Center	___County Educational Service Center	___Job & Fam. Serv	____Dept of Youth Serv
___Century Health	___Findlay City Schools	___Juvenile Ct	____Help Me Grow
___Fidelity EHR	___Other Schools	___Board of DD	_____EHR Database
___Practitioner	___Other Schools	___Brd. of Health	_____Other _____

NOTICE: this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR FURTHER INFORMATION:
Council Coordinator
Hancock County Family & Children First Council
308 Dorney Plaza Phone: (419) 424-7073
Findlay, OH 45840 FAX: (419) 424-7485

Notice of Cancellation

DATE: _____ Time:_____
Mode of Cancellation:_____
(telephone, letter, in-person,text)

Signature of person receiving Notice of Cancellation: _____