

**CHILDREN, YOUTH AND FAMILIES
WRAPAROUND REFERRAL**

CLIENT NAME: _____ SWCS ID# _____
 Gender: Male Female Date of Birth: _____ SS#: _____
 School: _____ Grade: _____
 Current Living Arrangements: _____

OTHER FAMILY MEMBERS:

Name	Relationship	Age	Address (If Different)	Telephone No.

PARENT/GUARDIAN: Spanish Speaking Only

 Last Name First Name Middle Initial Relationship to Youth

 Address City State ZIP

 Home Phone Work Phone Cell Phone

Legal Guardian: Yes No If No, please give explanation: _____

ELIGIBILITY CRITERIA: (check all that apply):

- Involved in at least two systems? Check all that apply:
 - Special Education If so, classification: _____
 - DHS Children and Family Services Mental Health Other: _____
- Youth is having behavior difficulties in school, home or community
- Youth is diagnosed with a severe emotional disturbance (SED)
- Youth is currently in out of home placement Youth is at risk of out of home placement
- Youth is a state ward (circle one: TCW, PA 150, MCI)

CAFAS Score (if applicable) : _____ Date: _____ CAFAS Rater: _____

Has a Psychiatric assessment been completed? Yes No

If yes, Date: _____ Psychiatrist _____

Diagnosis- Axis 1: _____ Axis II: _____

Signs/Symptoms to support diagnosis: _____

Significant Family Circumstances: _____

Concerns and Barriers: _____

Referring Agency's Goals: _____

REFERRAL SOURCE INFORMATION:

Agency Name and Address _____

Referring Worker _____ Title _____ Telephone _____

Supervisor _____ Telephone _____

CONSENT TO PARTICIPATE IN REFERRAL PROCESS:

I understand that I am being referred to Wraparound. I agree to meet with the Wraparound staff that will gather information and explain in detail the Wraparound process.

Signature Parent/Caregiver Date Signature Parent/Caregiver Date

Signature of Child/Youth Date Staff signature/Title Date

SEND REFERRAL TO: ATTN: Marquita Settles
Southwest Counseling Solutions 1700 Waterman Detroit, MI 48209
313 963-2266 (phone) 313-963-2472 (fax)

TO BE COMPLETED BY THE PROGRAM SUPERVISOR

Date referral received: _____ Service start date: _____

Assigned Worker: _____ Date Assigned: _____