Collaborations Contra Costa Youth Service Bureau

WRAPAROUND SERVICES REFERRAL FORM

Instructions: Please recommend minors that you feel have the most need and would benefit from wraparound services. Please fill out Sections 1, 2, & 3 as completely as possible. ****MUST COMPLETE**

Fax completed referral(s) to: (510) 231-7810

SECTION 1: Minor's Information

Date: _____ School: _____

Name of Minor: _____ Grade: _____ Academic Counselor: _____

**Date of Birth: _____Age: _____ Gender: □ Female □ Male □ Transgender

Ethnicity: _____ **Minor Language(s) Spoken: _____

(Referring party should make sure that family is aware of referral being made prior to making referral)

****OK TO CONTACT PARENT/GUARDIAN: __YES __NO **IS PARENT/GUARDIAN AWARE OF THIS REFERRAL? __YES __ NO**

**Parent/Guardian (1) Name: _____ Relationship: _____

Contact Phone Number: _____ Address: _____

**Parent/Guardian Language(s) Spoken: _____ City: _____

Parent/Guardian (2) Name: _____ Relationship: _____

Contact Phone Number: _____ Address: _____

Parent/Guardian Language(s) Spoken: _____ City: _____

****Minor's Social Security Number: _____**
****SS # must be provided to check for minor eligibility.**
(Minor must have Contra Costa County Medi-Cal to be eligible for CCYSB Wraparound services)

Insurance: □ Medi-Cal # _____

**SECTION 2: Reason for Referral (check all that apply)

□ Academic Performance
□ Health Care □ Runaway
□ Peers/Friends/Relationships
□ Housing/Shelter
□ Family Issues
□ Mental Health
□ Alcohol/Drug/Tobacco Concerns
□ Anger Management □ Self-Esteem
□ Depression
□ Truancy
□ Crisis (please specify): _____
□ Other: _____
□ I would rather discuss in person. ****Please elaborate on target behaviors/needs/problems:**

_____

_____

SECTION 3: Referral Source

**Name: _____ **Position: _____

**Agency: _____ **Phone and Ext: _____

Case Assignment: For Provider Use Only

Date: _____ Facilitator Assigned: _____

_____ West _____Central _____East Family Partner Assigned: _____