Contra Costa Youth Service Bureau

HIGH-FIDELITY WRAPAROUND PROGRAM REFERRAL FORM

Instructions: Please refer minors who would benefit from Wraparound Services.
Complete **Sections 1, 2, & 3** as thoroughly as possible. **All required fields are marked with** **
Submission: Please email completed form to wrapreferrals@wccysb.org or fax to: (510) 231-7810

SECTION 1: Minor's Information

Date: _____ School: _____

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

**Date of Birth: _____Age: _____ Gender: ☐Female ☐Male ☐Non-Binary ☐Other: _____

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

(Referring party must ensure the family is aware of this referral before submission.)

****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: _____ Insurance: ☐Medi-Cal # _____**

(SS# must be provided to check for eligibility. Minor must have Contra Costa County Medi-Cal to qualify for services.)

**SECTION 2: Presenting Concerns (check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Trauma/PTSD
- ☐ Behavioral Issues
- ☐ Family Conflict
- ☐ Crisis (please specify): _____
- ☐ Other (please specify): _____
- ☐ Grief/Loss
- ☐ Self-Esteem Issues
- ☐ Anger Management
- ☐ Stress Management
- ☐ I prefer discuss in person

****Please elaborate on target behaviors, needs or concerns:** _____

_____

SECTION 3: Referral Source

Referring Person's Name: _____ Position/Title: _____

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

CCYSB Interagency Information

Is the minor currently involved in other CCYSB programs? (Check all that apply)

- ☐ Kinship Services
- ☐ DR Path II & Aftercare Services
- ☐ Individual Therapy
- ☐ Other: _____

Date Agency Received Referral: _____ Initial Contact Date: _____
Assessment Appointment Date: _____ Clinician Assigned: _____
Date Opened: _____Care Coordinator Assigned: _____

Notes:_____

_____