Weld County System of Care

Wraparound Referral Form

REFERRAL SOURCE INFORMATION

Agency Making Referral:___________________________________ Date of Referral: _________________________

Contact Person: ____ Phone/Email: ____________________________

REFERRED FAMILY

Referred Youth: ____ Date of Birth: ____________________________

Name of Parent(s)/Guardian: _______________________________ Phone Number: ___________________________

Address: ____

School Youth Attending: ___________________________________ Preferred Language: _______________________

PROGRAM REFERRED

☐ High Fidelity Wraparound (HFW)
HFW focuses on long term intervention (6+ months) for high risk youth with high level needs.

☐ Early Intervention Supports (EIS)
EIS utilizes the same principles, methods and techniques as HFW with a focus on short-term intervention for younger offenders.

CHECK REFERRAL CRITERIA THAT APPLY

☐ Youth is between the ages of 9 -17 years old

☐ Youth has used Marijuana EVER in lifetime

☐ Youth displays symptoms of severe emotional or behavioral disturbance

☐ Family involved in **two or more** formal systems: (Please identify which programs within each system, if known.)

- ☐ **JUVENILE JUSTICE** (☐ Legal/ ☐ Courts *(any)*/ ☐ Probation/ ☐ G.A.L.) **Case/Ticket number(s): ____________________**
- ☐ **SUBSTANCE USE** (☐ Use/ ☐ Eval/ ☐ Diagnosis/ ☐ Treatment)
- ☐ **MENTAL HEALTH** (☐ Eval/ ☐ Diagnosis/ ☐ Treatment)
- ☐ **EDUCATION** (☐ IEP/ ☐ MAB/ ☐ EARSS/ ☐ HB/ ☐ 504)
- ☐ **HOUSING** (☐ FUP/ ☐ State / ☐ Sect. 8/ ☐ Homeless)
- ☐ **CHILD WELFARE** (Department of Human Services) (Specify how): ____
- ☐ **OTHER** (Specify): ____

ADDITIONAL INFORMATION Please explain checked boxes above! More space on 2nd page.

Wraparound process has been discussed with the family: Yes No

Please return to Wrap@YouthandFamilyConnections.org Questions? Call 970-351-5471

STAFF USE ONLY

Approval Signature: ____

Approval Date: ____

ADDITIONAL INFORMATION