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Tuscarawas County Family & Children First Council

Service Coordination – Referral Sheet

Tuscarawas County Family and Children First Council

This form is to refer your child or a child you are working with to the service coordination process through Family and Children First Council. The service coordination process focuses on multi-system need children, ages 0-21, with at-risk behaviors. The Goal of service coordination is to build upon family strengths, utilize and coordinate existing services and resources, strengthen and increase access to supports, and strategize to address a child and family's unmet needs.

Email to councilmanager@tcfcfc.org with Subject "New Referral, Youth Initials"

Fax to Tuscarawas County Family and Children First Council, ATTN: Council Manager **330-339-7539**

Referral Date: _____

IDENTIFIED YOUTH INFORMATION

Youth Name:		**Date of Birth:**
Sex:	**Race:**	**Youth phone # (if 18+):**
Address:	**City:**	**Zip:**
Current School:	**Grade:**	**Regular Ed or Special Ed**
Youth Social Security Number (used for State FCFC Documentation System):	**Ethnicity:**	**Private Insurance Carrier or Medicaid MCP:**

PARENT/GUARDIAN INFORMATION

Name:	**Relationship to youth:**	
Phone #:	**Alternative Phone #**	
Address (if different from youth):	**City:**	**Zip:**

MEMBERS IN HOUSEHOLD (other than youth and parent/guardian):

Name:	**Age:**	**Relationship to Youth:**

YOUTH INVOLVEMENT: Last 30 days – Check all that apply

	Juvenile Court		**Children Services/ JFS**		**Physician / Hospital**
	Department of Youth Services		**Board of Developmental Disabilities**		**Mental Health**
	Substance Abuse Treatment		**Respite**		**Other**
Comments:					

YOUTH NEEDS/CONCERNS: Check all that apply

	Alcohol/Drug		**Poverty**		**Special Education**
	Child Abuse		**Delinquent**		**Unruly**
	Help Me Grow		**Mental Health**		**Child Neglect**
	Physical Health / Medical		**Developmental Disabilities**		**Autism Spectrum Disorder**
	Primary Care Physician		**Behavior Problems**		**Legal Issues**
	Runaway		**Housing**		**School Problems**
	Suicidal		**Other:**		

Reasons for referral / Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is youth at risk for placement out of the home? YES / NOIf yes, rate the risk (1-low, 10-high) _____

Is the youth in need of transition/step-down services back to the community? YES/ NO

Is the youth/family in need of support and/or services to maintain the youth in the home/community? YES / NO

Is the youth at risk of juvenile court involvement? YES / NO / NA

Has the family been educated and agreeable to this referral to service coordination? YES / NO / NA

Referral completed by: _____ **Agency:** _____

Phone: _____ **Email:** _____

Please have the youth (if 18+) or parent/guardian sign the FCFC release of information and submit with this referral

To be completed by Service Coordinator:

Date received: _____ First contact: _____ VM: _____ Second contact: _____ VM:_____