Tuscarawas County Family and Children First Council
Service Coordination
Referral Sheet

The purpose of this form is either 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-need children up to the age of 21. The goal of service coordination is to build upon family strengths, utilize and coordinate existing services and resources, strengthen and increase access to formal and informal supports, and strategize to address a child and family's unmet needs. Upon completion of this form fax it to Tuscarawas County Family and Children First Council, ATTN: Service Coordinator at 330-364-3307, email the form to servicecoordinator@tcfcfc.org, or mail to TCFCFC Service Coordination P.O. Box 1017 New Philadelphia, Ohio 44663.

IDENTIFIED YOUTH **Date of Referral:** _____

Youth Name: _____ Date of Birth: _____

Sex: Female Male Race _____

Address: _____

City: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Current School: _____

Grade: _____ Regular Ed Special Ed

PARENT/GUARDIAN INFORMATION

Name: _____

Relationship to Youth: _____

Home Address: _____

- Check if same as above

City: _____ Zip: _____ E-mail _____

Home Phone: _____
Cell Phone: _____

Employer: _____
Work Hours:

# of Members in Household? _____

Sibling: Age:
Sibling:
Age:

Reason Referred for Services or Supports? _____

Is the youth at risk for placement out of the home? YES NO

Please continue on back

If yes, rate the risk (1=low, 10= high risk of placement) _____

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

Is 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

Has the family been educated regarding this referral? YES NO NA

Is the family agreeable to service coordination? YES NO NA

CURRENT YOUTH INVOLVEMENT
LAST 30 DAYS
(check all that apply)

- ☐ Juvenile Court
  - ☐ Detention
  - ☐ Probation
- ☐ DYS Parole
- ☐ Children Services
  - ☐ Investigation
  - ☐ Voluntary Case Plan
  - ☐ Custody
  - ☐ Protective Supervision
- ☐ Hospital
  - ☐ Medical
  - ☐ Mental Health-Psych
- ☐ MRDD
- ☐ Mental Health
  - ☐ Outpatient Counseling
  - ☐ Medication Management
- ☐ Substance Abuse Treatment
  - ☐ Outpatient
  - ☐ Inpatient
- ☐ Respite (out of home)

YOUTH CONCERNS/NEEDS					
☐	Alcohol/Drug	☐	Child Abuse	☐	Child Neglect
☐	Delinquent	☐	Developmental Disabilities	☐	Mental Health
☐	Physical Health	☐	Poverty	☐	Special Education
☐	Unruly	☐	Other	☐	Other

_____ _____ _____

Form completed by Agency Phone

To be completed by Service Coordinator:

Has ROI been obtain from referral source? Yes No NA
Date received: _____
Date of initial contact: _____
Date of assessment meeting: _____
Date of family team meeting: _____
Have ROIs been obtained for family supports, service providers, etc.? Yes No NA