Referral for Multisystem Services

Please submit the Referral & Release of Information to:
Brenda Rock, Champaign County FCFC Director
Address: 1512 S. US Hwy 68 Suite N100
Urbana, OH 43078
Phone: 937.653.4490
Fax: 937.652.2648
E-mail: Brenda.rock@jfs.ohio.org

Eligibility Criteria:

1. Youth must be a **resident** of Champaign County
2. Youth must be under the age of 22 years
3. Youth must have **multiple-system unmet needs**
4. **Completed Referral form & Release of Information**

Date of Referral
Click or tap to enter a date.

Name of person making referral: Click or tap here to enter text. Relationship to youth: Click or tap here to enter text. Phone Number: Click or tap here to enter text.	Address: Click or tap here to enter text. Email Address: Click or tap here to enter text.

1. Last Name: First Name: Middle:

   Type in Name

2. DOB: Click or tap to enter a date. 3. Gender: ☐ M ☐ F ☐ non-binary

4. Race Ethnicity: ☐Hispanic ☐ Non-HIspanic

5. Currently living with: Relationship to child:Click or tap here to enter text.

5. Who has custody of the child? Click or tap here to enter text.
6. Relationship to child:Click or tap here to enter text.

7. School District of Residence:______________________________

7a. Is this child on an IEP? ☐ Yes ☐ No
If yes, reason: Click or tap here to enter text.

7b. School District Attending:________________
Grade:_______
How long has child attended this school?: _____

8. Who lives in the household with this youth?

Name	Relationship	Age
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	
Click or tap here to enter text.	Click or tap here to enter text.	

9. Child's Current Address:
Click or tap here to enter text.

Parent(s) Address (if different):
Click or tap here to enter text.

Phone Number:Click or tap here to enter text.
Email address:Click or tap here to enter text.
When is the best time contact the family?
Click or tap here to enter text.

CHAMPAIGN COUNTY
FAMILY & CHILDREN FIRST COUNCIL

12. Briefly describe the presenting problem or areas of need. Please include the length of time the problem has existed:

Click or tap here to enter text.

13. Reasons for Referral (check all that apply)

☐Developmental Disabilities ☐ Financial ☐ Housing
☐Mental Health ☐ Legal Issues ☐Autism Spectrum Disorder
☐Substance/ Alcohol Abuse ☐ Child Abuse/Neglect ☐Poverty
☐Special Education ☐Physical Health ☐ Unruly
☐Early Intervention ☐ Behavior Problems ☐Aggression/ Assault
☐Emotional Disability ☐ Death of a Parent ☐ Family Conflict

14. Does the youth have any diagnoses?
Click or tap here to enter text.

15. Youth's Current Medications:
Click or tap here to enter text.

16. Family is aware of referral. ☐Yes ☐ No

17. Family wants to participate. ☐Yes ☐ No

18. Who else is currently involved with youth? Select all that apply:

☐Children's Services ☐Juvenile Court ☐ Mental Health Provider ☐Developmental Disabilities ☐School ______________________________

☐Physician/ Hospital ☐Other ______________________________

19. Please use this space to write additional important information:

Click or tap here to enter text.

UNIVERSAL RELEASE OF CONFIDENTIAL INFORMATION

Name of Youth: ____ Date of Birth: ____________________________________

As parent or legal guardian, I authorize the following **initialed** agencies to obtain and release information regarding
____. (**Please DO NOT use check marks. Parent/Guardian must put initials.**)
Please initial any agencies you are currently working with, or that we may work with in the Wraparound process.

*_____ Logan-Champaign Counties Mental Health, Drug and Alcohol Services Board
*_____ Champaign Co. Family and Children First/CFT/Diversion Team
*_____ Madison-Champaign ESC
______ Board of Education (District of Residence/Attendance): ____
______ Mac-A-Cheek Learning Center
______ Champaign Co. Board of Developmental Disabilities
______ Champaign Co. Department of Health, including WIC/BCMH
______ Champaign Co. Department of Job & Family Services, including Children Protective Services
______ Champaign Co. Domestic Relations-Juvenile-Probate Court
______ Champaign Co. Early Intervention
______ Nationwide Children's Hospital
______ Dayton Children's Hospital
______ TCN
______ Urbana Family Medicine & Pediatrics
______ Oesterlan Services for Youth, Inc.
______ Well Spring
______ Parent Mentor, Jacqueline Howley
______ Other: ______________________________
______ Other: ______________________________
______ Adriel
______ Choices
______ Respite Connections
______ Residential Administrators
______ Caring Kitchen
______ Parent Advocate (PAC)
______ OASCIS ___________________________
______ CANS ___________________________
______ Ohio Rise: ___________________________

The agencies **initialed** above may share with each other, the following information in order to develop a service plan for the above named youth.

*_____ Medical Records
*_____ Children's Protective Services Information
*_____ Scholastic/Attendance Records
*_____ Psychological Reports
*_____ Psychotherapy Records
*_____ Verbal Exchange of Information
*_____ ______________________________
*_____ ______________________________

I further understand that these records are protected by state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time.
This consent expires automatically 180 days from the date signed.

Signed this __________ Day of __________________________________, 2_____________

Signature of Parent or Guardian: ____

Witness: ____

Revoked/date: ______________________ Signature: ____

Witness: ____

IF YOU RECEIVE INFORMATION RELEASED WITH THIS FORM THE FOLLOWING FEDERAL LAW APPLIES TO YOU: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part2), The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other-wise permitted by 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.