



## Wraparound Referral

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_ Address/Email: \_\_\_\_\_

PLEASE CHECK THE FOLLOWING STATEMENTS ABOUT THE CHILD/FAMILY:

- |   |           |          |              |
|---|-----------|----------|--------------|
| 1. Child is currently out of home and looking to return:            | Yes _____ | No _____ | Unsure _____ |
| 2. Child is at risk of being placed out of the home:                | Yes _____ | No _____ | Unsure _____ |
| 3. Child has an SED or Special Needs diagnosis:                     | Yes _____ | No _____ | Unsure _____ |
| 4. Parent has a Mental Illness diagnosis:                           | Yes _____ | No _____ | Unsure _____ |
| 5. Three or more service providers involved with this family:       | Yes _____ | No _____ | Unsure _____ |
| 6. The family has informal supports who are willing to participate: | Yes _____ | No _____ | Unsure _____ |

(If NO or UNSURE: Please identify potential informal supports with the family to be a part of the Wraparound process.)

**\*\*\*Families and Service Providers MUST be ready, willing and able to fully embrace and participate in the philosophy of Wraparound.\*\*\***

Family Name: \_\_\_\_\_

### Family Members:

Names-list all	Relationship	Address	Phone(s):	Date of Birth
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Marital status of parents: (circle one)    Married    Never Married    Separated    Divorced    Widowed

### Possible persons to invite (examples: extended family, friends, teachers, therapist, neighbor etc.):

Name	Relationship	Phone	Name	Relationship	Phone
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		



Reason for referring to the Wraparound Process:

Four horizontal lines for text entry.

Family Identified Areas of Concern (mark all that apply):

Box containing a list of 13 categories with checkboxes: Family, Community, Friends/ Social, Health, Emotional/Behavioral, Legal, Cultural/Spiritual, Work, Educational, Safety, Basic Needs, Financial, Other.

Issues that may be beneficial for the Wraparound facilitator to be aware of in organizing this meeting:

Three horizontal lines for text entry.

Special needs of child/family (physical/medical, language/other cultural):

Three horizontal lines for text entry.

By signing this referral, I, \_\_\_\_\_, permit my family to be referred to the Wraparound Program.

Client Name (Print)

Client or Guardian Signature/Relationship

Date

Client Name (Print)

Client

Date

\*Signed and Dated Release of Information Required\*

Please email completed referral form to MRHD@thevillagefamily.org