Wrap Connections Referral Form

Referring Party Information:

Agency *(if applicable)*	
Name	
Email	
Phone Number	
Fax Number	

Referral Criteria (check all that apply):

☐	Youth is a full-scope Medi-Cal beneficiary under age 21
☐	Youth has mental health or behavioral concerns and is not affiliated with Probation or Child Welfare
☐	Youth has recently been at ESU or inpatient psychiatric hospitalization
☐	Youth is currently at risk for moving to a different living arrangement
☐	Other- please explain.

Reason for Referral:

Please enter a short paragraph describing the current child and family needs. What are the mental health or behavioral concerns that need to be addressed? What is the reason for the referral to this program?

Youth Information:

Youth Name:	Date of Referral:
DOB:	Age:
Race/Ethnicity:	Language Preference:
Gender Identification:	

Caregiver Information:

Name	Relationship
Phone Number:	Email:
Address:	Language Preference:

Release of Information attached ☐	**Verbal Consent Received** ☐

Please send completed referral to wrapconnections@fredfinch.org or fax to (619)797-1091

Rev.1/13/2022

Please complete the following section with as much information as possible:

Please describe relevant youth and family dynamics or information that will be important to include during services:

Has the youth/family agreed with referral to Wraparound? ○ YES ○ NO

Add additional comments if necessary

Youth/Family Risk Factors- please mark all that apply:

☐ Suicidal Ideation/Behaviors	☐ Physical aggression
☐ Homicidal ideation/behaviors	☐ Domestic violence

Overall safety considerations:

What other services does the youth or family currently have or participate in? for instance, therapy, TBS, other providers. May also include extracurricular activities, etc.

Please describe strengths of the youth and family

FF ADMIN USE ONLY
Medi-Cal Check ☐

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