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 is non-system involved and has mental health or behavioral concerns
☐	Youth has recently been at ESU or inpatient psychiatric hospitalization
☐	Youth is currently at risk for moving to a different living arrangement
☐	Other

Reason for Referral:

Please describe the youth 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:	Medi-Cal ID:

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.11/17/2025

LIVE WELL SAN DIEGO | COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY

Please complete the following section with as much information as possible

Please describe youth and family dynamics that will be important for Wraparound to consider:

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
☐ Substance Abuse	☐ History of Hospitalization

Overall safety considerations:

What other services does the youth or family currently have or participate in? (i.e. Therapy, TBS, other providers, extracurricular activities, etc.):

Please describe strengths of the youth and family:

FF ADMIN USE ONLY
Medi-Cal Check ☐

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

Rev.11/17/2025