



Fairfield County Family Adult Children First Council Multi-System Youth Program Referral Packet

Household Members

Name	Age	Relationship

Current School Information

School District _____

School Attending _____

Current Grade Level _____

IEP or 504? _____

Describe School behavior & performance:

Current System Involvement

	Yes	No
CPS		
Juvenile Court		
Developmental Disabilities		
Mental Health Agency		
OOD		
OhioRISE		

MSY Use Only

(list agency name, name & contact information of provider, and type of service/involvement in next section)



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Current System Involvement

Agency Name	Contact Information & Involvement

MSY Use Only

Youth Physical & Mental Health Information

Primary Care Phycsian _____

Physical Health Concerns/diagnosis: _____

Has youth ever had a Psychological Evaluation? _____

If yes, When & Where? _____

Mental Health Diagnosed Conditions: _____

Medications: (name & dosage)



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Youth and Family Strengths

Family relationship and stability		Friends & interpersonal skills	Positive/optimistic
Schools—grades, behavior, relationships, and attendance		Vocation/Employment — interest, skills, goals	Community involvement
Youth's participation with care or providers		Natural supports (non-family or professional)	Supervision & parenting
Parent/caregiver's participation with providers		Self and/or family advocacy	Resource knowledge
Transportation		Self-esteem	Spiritual/Religious connection

MSY Use Only

Describe what youth enjoys, talents, skills: _____

Describe family activities and family relationship: _____

Does the Caregiver have any history of or current needs listed below?

	Current	History
Substance Use Issues		
Unemployment		
Domestic Violence		
Previous CPS Case		
Mental Health Issues		
Housing Problems		

Email completed Referral Packet to : msyreferrals@fairfieldcountyohio.gov or fax to (740)681-5540

include signed ROI and any supporting documentation you would like to send.