Fairfield County Family, Adult and Children First Council

Multi-System Youth Referral Packet

Address: 831 College Avenue, Suite C., Lancaster Ohio 43130 Fax: (740) 681-5540

Check one: **Early Childhood Cluster** ☐ (birth to age 8) **I-Team** ☐ (age 9 to 22)

Referral Date: _____ Name of Youth: _____

Date of Birth: _____ Gender: _____ Race: _____

Referring Person/Agency: _____

Phone: ( ) _____ Email:_____

Possible Services Requested: _____

- Mother: _____ Employer: _____

  Address: _____ City: _____

  Home Phone: ( ) _____ Cell: ( ) _____

  Email:_____

- Father: _____ Employer: _____

  Address: _____ City: _____

  Home Phone: ( ) _____ Cell: ( ) _____

  Email:_____

- Legal Custodian: _____ Relationship to Youth:_____
  (if different from parents)

  Address: _____ City: _____

  Home Phone: ( ) _____ Cell: ( ) _____

  Email:_____

Child currently resides with: (mark all that apply)

☐ Mother ☐ Father ☐ Legal Custodian ☐ Foster Care

Siblings Living in the Home	Date of Birth

Other Adults Living in the Home	Relationship to the Child

(Please use the back to include additional children and/or adults)

Agency Involvement (check all that apply)

☐ Child Protective Services Caseworker: _____

☐ Juvenile Court Probation Officer: _____

Charges: _____

☐ Developmental Disabilities Individual Support Coordinator: _____

Diagnosis: _____

☐ HMG, EHS, HS (circle) Coordinator/Visitor/Teacher: _____

Mental Health (if applicable)

Therapist: _____ Agency:_____

Psychiatrist: _____ Agency: _____

Has the child had a psychological assessment? ☐ Yes ☐ No Date: _____

Diagnosis: _____

Medications: _____

Mental Health ER Visits or Hospitalization:_____

School Information

Home School: _____ School of Attendance: _____

Does the child have an IEP? Yes or No Grade: _____

Educational Placement:

☐ Regular ☐ Cognitive Disability (CD) ☐ Multiple Disabilities (MD) ☐ Autism

☐ Emotional Disturbance (ED) ☐ Other Health Impairment (OHI) ☐ Visual Impairment

- Explain school behaviors and academics: (any suspensions, grades, 504 plan, etc.)

Child's History and Presenting Risks & Needs

Please check all that apply:

	Suicidal ideations, attempts		Impulsive behavior/poor judgement		Domestic Violence/ Witness or Victim
	Self-injurious behavior		Hears voices/sees things		Homelessness
	Aggressive toward others		Eating disorder		Isolation, no natural supports
	Cruelty toward animals		Suspensions, expulsions		Parent/caregiver or youth with chronic illness
	Fire setting		Truancy		Availability of weapons
	Physical abuse, sexual abuse and/or neglect (circle)		Drugs and/or alcohol use		Depression, anxiety or opposition (circle)
	Sexual acting out		Bullying/Bullied		Trouble sleeping
	Running away		Unrestricted technology access		Pro-social activity/ socialization
	Cultural/environmental struggles (in-home)		Family stress, tension and/or arguing		Living situation/function
	Communication skills		Self-care		Independent living skills (14-21 only)
	Recreation/physical activity—limited amount/access/ability		Other (please specify):		

- Describe the child's at risk history and the reason for being referred to MSY:

- What options have been tried? What has worked and what hasn't?

Child and Family Dynamics & Strengths Check all strengths for both child and/or family:

	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

Child's Interests & Activities:_____

Family Interests & Activities:_____

- Describe how the family gets along and interacts with each other. Who are the family's natural supports?

- Describe the child's relationship with peers, adults, authority figures.

- Does anyone in the home have any physical activity limitations? (Ex.: Asthma)

Financial Statement (Used to identify potential funding sources and not MSY program eligibility.)

Monthly gross income—mother: _____ Monthly gross income—father:_____

Monthly gross income—guardian(s): _____ Other Income: _____
(adoption, child support, kinship, SSI/D)

Total monthly income: _____

Assistance (food, rent, childcare, etc.):_____

Insurance

☐ Private insurance Provider: _____

☐ Medicaid Managed Care Provider: _____
(ex: Molina, Caresource)

Primary Care Physician's Name: _____