ERIE COUNTY COMMUNITY-BASED SUPPLEMENTAL REFERRAL
CHILDREN'S SINGLE POINT OF ACCESS REFERRAL
SUPPLEMENTAL WRAPAROUND REFERRAL

Client Name: _____
First Name **Last Name**

Date of Birth: _____
(Month/Day/Year: XX/XX/XXXX)

PARENT/CAREGIVER INFORMATION 1:

First Name:	**Last Name:**	**Race/Ethnicity:**	**Primary Caretaker** ☐ **Yes** ☐ **No**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Relationship to Child(ren):**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Address:			
City, State:	**Zip Code:**		

PARENT/CAREGIVER INFORMATION 2:

First Name:	**Last Name:**	**Race/Ethnicity:**	**Primary Caretaker** ☐ **Yes** ☐ **No**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Relationship to Child(ren):**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Address:			
City, State:	**Zip Code:**		

PARENT/CAREGIVER INFORMATION 3:

First Name:	**Last Name:**	**Race/Ethnicity:**	**Primary Caretaker** ☐ **Yes** ☐ **No**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Relationship to Child(ren):**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Address:			
City, State:	**Zip Code:**		

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PARENT/CAREGIVER INFORMATION 4:			
First Name:	**Last Name:**	**Race/Ethnicity:**	**Primary Caretaker** ☐ **Yes** ☐ **No**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Relationship to Child(ren):**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Address:			
City, State:	**Zip Code:**		

CASE COMPOSITION (Other than Primary Caregivers, who else lives in the home)			
CAREGIVER 1			
First Name:	**Last Name:**	**Gender:**	**Date of Birth:**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Race/Ethnicity:**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Current Residence Address (include City, State and Zip Code):			
Relationship to Child(ren):			
CAREGIVER 2			
First Name:	**Last Name:**	**Gender:**	**Date of Birth:**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Race/Ethnicity:**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Current Residence Address (include City, State and Zip Code):			
Relationship to Child(ren):			
CAREGIVER 3			
First Name:	**Last Name:**	**Gender:**	**Date of Birth:**
Refugee/Immigrant ☐ **Yes** ☐ **No**	**Race/Ethnicity:**	**Active Medicaid (MA)** ☐ **Yes** ☐ **No**	**CIN Number:**
Current Residence Address (include City, State and Zip Code):			
Relationship to Child(ren):			

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Please add any additional Caregivers on the last page
Do any of these individuals identify self with another preferred name? If yes, who and by what?
Is anyone in Case Composition affiliated with a Health Home? If yes, who and where?

School Information (for each child):		
Child's Name:	Name of School:	Current Grade:

Please add any additional School Information on the last page

Legal Custody Status (check all that apply and list children in each status)
☐ **Joint/Both Parents:**
☐ **Birth Father Only:**
☐ **Birth Mother Only:**
☐ **Adoptive Parent:**
☐ **Article 6 Permanent Custody:**
☐ **1017 Temporary Custody:**
☐ **Guardianship:**
☐ **Foster Care:**
☐ **Other:**

For any child NOT living with biological parent(s), list who has custody of each child and provide contact information			
Child's Name:	**Individual Child is living with:**	**Address:**	**Phone Number:**

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REASON FOR REFERRAL
Eligibility Criteria for Preventive Services:
Health and Safety of the Child: This standard recognizes that a primary target group for preventive services is families in which there have been incidents of child abuse or maltreatment.
Refusal: This standard applies when parents or caretakers have refused to maintain the child in the home or have expressed an intention of surrendering the child for adoption.
Parent Unavailability: This standard is used when the child's parents or current caretakers have become unavailable due to: Hospitalization, Arrest, Detainment or Imprisonment, Death, or their whereabouts are unknown.
Parent Service Need: This standard applies when a parent or caretaker has a condition that impairs his/her ability to care for the child. This may include alcoholism, drug abuse, mental illness, or any other impairment that hinders the person's ability to parent. It also may include a financial condition that makes it difficult or impossible for the parent or caretaker to provide adequate housing or meet other basic family need.
Child Service Need: This standard is used when a child has special needs for supervision or services that cannot be adequately met by parents or caretakers without intensive services, resulting in the child being at-risk of foster care placement without such services.
Pregnancy: This standard applies when a mother is pregnant or has given birth and has shown an inability to provide adequate care for her unborn or infant child.

REASON FOR REFERRAL	
HOME ENVIRONMENT:	
Who is in need of Intervention? ☐ Parents/Caretakers ☐ Child(ren)	
Reasons for Referral (Select all that apply):	
☐ Children's Whereabouts Unknown	☐ Parent's Whereabouts Unknown
☐ Criminal Activity in Home	☐ Abuse resulting in Hospitalization
☐ Severe/Chronic Parent/Child Conflicts	☐ Previous TPR/Surrender
☐ Prior Child Welfare Involvement	☐ Domestic Violence
☐ Death of a Child as a Result of Abuse	☐ Death of a Child
☐ Death of a Caregiver	☐ Inadequate Supervision
☐ **Other Reason for Referral, please specify:**	

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Explain details relating to any box checked above (provide who, frequency, intensity, etc.).
Please specify if any known safety concerns for staff entering the home.
Are basic needs being met (ex. food, bedding, shelter, working utilities)? ☐ Yes ☐ No
If you selected above, please explain:
SUBSTANCE ABUSE
Who is need of Intervention? ☐ Parents/Caretakers ☐ Child(ren)
Substance being used and frequency of use.
Substance Abuse Treatment: ☐ Yes ☐ No
If yes to Substance Abuse Treatment: ☐ Past ☐ Present
Has there been any inpatient treatment for the Substance Abuse: ☐ Yes ☐ No
If yes to inpatient treatment: ☐ Past ☐ Present
Was there a positive toxicology test at birth? ☐ Yes ☐ No
If yes, please explain (who, frequency, intensity, etc.):

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SCHOOL
Who is in need of Intervention? ☐ Parents/Caretakers ☐ Child(ren)
School Reasons for Referral (Select all that apply and specify below): ☐ Repeated Grades ☐ Educational Neglect ☐ Suspensions ☐ Truancy ☐ Special Education ☐ Dropout ☐ Failures/Failing ☐ Agression ☐ Pervasive Developmental Disability/OPWDD IEP
☐ Other (please specify):
Explain (who, frequency, tendency, etc.):

MENTAL HEALTH
Who is need of Intervention? ☐ Parents/Caretakers ☐ Child(ren)
Mental Health/Behavioral Health Reasons for Referral (Select all that apply and specify below) ☐ Hospitalizations (past) ☐ Any suicidal or self-injurious behaviors ☐ Hospitalizations (present) ☐ Mental Health History / Diagnosis / Treatment ☐ Eating Disorder ☐ Trauma (sexually acting out / cruelty to animals / domestic violence / abuse / trauma / grief / adjustment related problems) ☐ CPEP: ☐ Past ☐ Present
☐ Other (please specify):
Explain (who, frequency, tendency, etc.):

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Diagnostic Information (*if available*):
Who is Diagnosed:
Primary Diagnosis (DX):
Secondary Diagnosis (DX):
Date of Diagnosis:
By Whom:
Prescribing Doctor:
Prescribed Medication:

Please add any additional Diagnostic Information on the last page

COMMUNITY BEHAVIORS
Who is need of Intervention? ☐ Parents/Caretakers ☐ Child(ren)
Community Behavior Reasons for Referral (Select all that apply and specify below) ☐ Delinquent Peer Group ☐ Property Damage ☐ Gang Involvement / Affiliation ☐ Fire setting ☐ Aggression / Violence ☐ Police Involvement ☐ Stealing ☐ Legal Involvement ☐ Limited Peer Involvement
☐ Other (please specify):
Explain (who, frequency, tendency, etc.) include past or present:

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MEDICAL	
Who is need of Intervention?	☐ Parents/Caretakers ☐ Child(ren)
Medical Reasons for Referral (Select all that apply and specify below)	
☐ Lack of Medical or Dental Care	☐ No Primary Care Linkage
☐ Malnutrition	☐ Medical Diagnosis
☐ Failure to Thrive	☐ Positive Toxicology (continued use)
☐ Other (please specify):	
Explain (who, frequency, tendency, etc.):	
PCP Name:	
Contact:	

SYSTEM INVOLVEMENT (SELECT ALL THAT APPLY):					
System	**Past Y/N**	**Present Y/N**	**Contact Person**	**Phone #**	**Name of Family Member(s) Involved**
☐ ECDSS – Child Welfare					
☐ Family Court Involvement					
☐ Drug Court Involvement					
☐ Criminal Court Involvement					
☐ OMH					
☐ OPWDD					

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ADD ANY ADDITIONAL INFORMATION TO THIS PAGE