TO BE COMPLETED BY CLINICIAN COMPLETING FORM:

CLINICIAN NAME: _____

DATE _____

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

Client Name: _____ **Fidelity #:**_____
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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SUPPLEMENTAL WRAPAROUND REFERRAL

PARENT/CAREGIVER INFORMATION:

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:**	

Please add any additional Caregivers on the last page

CASE COMPOSITION (children living in the home)
I

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):			
School Name:			
Grade:			
Who has legal custody:			

CASE COMPOSITION (children living in the home)
II

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):			
School Name:			
Grade:			
Who has legal custody:			

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CASE COMPOSITION (children living in the home)			
III			
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):			
School Name:			
Grade:			
Who has legal custody:			

CASE COMPOSITION (children living in the home)			
IV			
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):			
School Name:			
Grade:			
Who has legal custody:			

CASE COMPOSITION (children living in the home)			
V			
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):			
School Name:			
Grade:			
Who has legal custody:			

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CASE COMPOSITION (children living in the home)			
VI			
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):			
School Name:			
Grade:			
Who has legal custody:			

Do any of these individuals identify self with another preferred name? If yes, who and by what?

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

Please add any additional School Information on the last page

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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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FOR COMMUNITY / JJ REFERRALS - Please check all that apply

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.

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REASON FOR REFERRAL

HOME ENVIRONMENT
Who is in need of Intervention? ☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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:**

Explain the 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 "No" above, please explain:

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SUBSTANCE ABUSE
Who is need of Intervention? ☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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.):

SCHOOL
Who is in need of Intervention? ☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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.):

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MENTAL HEALTH
Who is need of Intervention? ☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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.):

DIAGNOSTIC INFORMATION (*if available*)
☐ **Denies any diagnosis**
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

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COMMUNITY BEHAVIORS	
Who is need of Intervention?	☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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:	

MEDICAL	
Who is need of Intervention?	☐ Parents/Caretakers ☐ Child(ren) ☐ N/A
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:	
Children Linked: ☐	

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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 *Confirm in CONNECTIONS*					
☐ Family Court Involvement					
☐ Health Home					
☐ Drug Court Involvement					
☐ Criminal Court Involvement					
☐ OMH					
☐ OPWDD					
☐ Other (please specify):					

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ADD ANY ADDITIONAL INFORMATION TO THIS PAGE