Child/Youth FSP WRAPAROUND Program Referral Form

Please fax completed form to:
Access Program: (510) 346-1083fax
1-(800) 491-9099ph

TO BE ELIGIBLE for these programs, Child/Youth must;
- ☐ Have Full-Scope Medi-Cal, be Indigent, or Undocumented
- ☐ Not be under jurisdiction of Child Welfare (CFS) or Probation

Priority Populations: Children/Youth who meet SED or Moderate-Severe criteria and criteria below:

☐ **Birth to 8: one of the following**
- ☐ **Reduction in preschool hours** and/or need for instructional aide in classroom due to behaviors;
- ☐ **Expulsion from preschool/elementary school** OR two suspensions from preschool/elementary school in one month;
- ☐ **Lack of sufficient progress** after 6-months of consistent outpatient treatment as measured by the provider and parent report

☐ **Ages 8 – 18: one of the following**
- ☐ **Repeated Hospitalization: one** in this sub-category
  - ☐ Three times in the last six months ☐ Twice in the last month
  - ☐ Three visits to Crisis Stabilization Unit (CSU) in a month
- ☐ **Other Category: two or more** in this sub-category
  - ☐ Failed multiple appointments ☐ School absenteeism ☐ Risk of homelessness
  - ☐ High score for Trauma on CANS
- ☐ **Lack of sufficient progress in consistent Therapeutic Behavioral Services (TBS) services** after six months of treatment, as per TBS provider and parent reports.

Client Information:

Name:_____ Date of Birth:_____ Ethnicity:_____

Gender: ☐ Male ☐ Female ☐_____ Preferred Language_____ SSN or PSP:_____

Full-Scope Medi-Cal: ☐ Indigent: ☐ Undocumented: ☐ County of Medi-Cal (if not Alameda)_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Alternate Contact:_____

Youth Resides with: ☐ Parent ☐ Relative ☐ Other:_____

Caregiver's Name(s): _____ Phone #: (___) _____ Alt. Phone #: (___) _____

Caregiver Preferred Language:_____ Understands English ☐Yes ☐No

Relevant Cultural Factors: _____

Referring Party/Program Information (if client has a primary therapy/meds program fill out below):

Name of Referring Party:_____ Title_____

Referring Program: _____ Phone:_____

Psychiatrist:_____ Phone:_____

Diagnosis:_____ Medications:_____

Please describe specifically the client's circumstances & behaviors that require FSP WRAPAROUND Services

Significant history or area of need affecting behavior(s): (check all that apply, and give specifics)

- ☐ Immediate Safety Concern/Risk Factors_____
- ☐ Trauma History_____
- ☐ Family/Social _____
- ☐ School_____
- ☐ Client Strengths & Interests_____
- ☐ Medical Conditions_____
- ☐ SUD Issues/Other_____

Include with this referral (if available):

- ☐ Clinician Assessment, Treatment Plan & CANS
- ☐ Psychiatrist/MD/NP Assessment, Med List & Labs

Consent for referral to FSP WRAPAROUND PROGRAM

I give consent for _____ being referred to the Child/Youth FSP Wraparound Program.

Signed:_____ Print Name:_____ Date_____
(Parent/Caretaker/Legal Rep) (Parent/Caretaker/Legal Rep)

This consent is subject to revocation by the undersigned at any time and if not earlier revoked, and shall terminate one year from the date of signing this release.