alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

# Child/Youth FSP WRAPAROUND Program Referral Form

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

**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 10: one of the following**
- ☐ **Lack of sufficient progress** after 6-months of consistent outpatient treatment as measured by the provider and parent report
- ☐ **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
- ☐ **Other Category: two or more** in this sub-category
  - ☐ Failure to meet developmental milestones ☐ Recent psychiatric hospitalizations ☐ Risk of homelessness

☐ **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 WRAP AROUND 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

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**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.***