Intake Form

Referral Information

County: _____

Referral Date: _____ Referral Source: _____

Youth Id: _____

Referral Source Information

Referral Source Name: _____
First *Last*

Agency Name: (if applicable) _____

Phone: _____

Email Address: _____

Signed consent/release of information has been uploaded ☐ Date(s) of signature: _____

Youth Information

Full Name: _____ Birth Date: _____
Last *First* *M.I.*

Preferred Name: _____
If different from Legal Name

Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Other _____

Preferred Language: _____

Race: _____

Ethnicity: ☐ Declined to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Was youth previously adopted? ☐ Yes ☐ No

If yes, age at adoption: ___ years

Address: _____ _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Youth Information (continued)

Email Address: _____

Phone: _____ Primary ☐ Yes ☐ No

_____ Primary ☐ Yes ☐ No

Can receive text messages? ☐ Yes ☐ No

Current living situation: _____

If independent living selected, what is the current living arrangement?

_____

Insurance and Physician Section

Does youth have Insurance? ☐ Yes ☐ No

☐ Medicaid ☐ Private

Private

Insurance Carrier: _____ Plan #: _____

Coverage Number: _____ Start Date: _____ End Date: _____

Medicaid

Insurance Carrier: _____ Plan #: _____

Coverage Number: _____ Start Date: _____ End Date: _____

Does the youth have a primary care physician? ☐ Yes ☐ No

If yes,

Primary Care Physician Name: _____

Primary Care Physician Phone: _____

Primary Care Physician Email Address: _____

Services and Support Section

Youth Strengths:

Family Strengths:

What other systems are involved in the care of the youth?

Household/Family Section

Are interpreter services needed to communicate with any members of the household? ☐ Yes ☐ No

If yes, language needed: _____

Safety Hazards within the home? ☐ Yes ☐ No

If yes, select all that apply:

When is the best time to reach the family? _____

Other Household Members

Name	Age	Relationship	System Involved?

Out of Home Placement Information

Has the youth ever been in any out-of-home placement (not including respite care)? ☐ Yes ☐ No

Has the youth ever been in a residential placement? ☐ Yes ☐ No

Was youth in out-of-home placement at the time of referral? ☐ Yes ☐ No

If you answered yes to any of the questions above, provide where the youth was placed and dates of placement:

Placement Location/Name	From (mo/year)	To (mo/year)

Is the youth at risk of a residential placement? ☐ Yes ☐ No

History and Desired Outcomes

Brief History:

How would the youth benefit from a multi-system team? What is the desired outcome from participation in Service Coordination/Wraparound:

Precipitating events leading to this referral:

What services and supports have been utilized to date?

Any additional information we should know as part of this referral?
(If the youth has a caseworker/probation officer/case manager/etc., please include this person(s) name and contact information)

Resource Eligibility

Resource Explored?	Child/Family Eligible?	Reasonably Exhausted?
Adoption Assistance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Child Support	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Home Energy Assistance Program(HEAP)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Local Developmental Disabilities Board	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Local Mental Health/Addiction Board	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Medicaid/Medicaid Managed Care	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Metropolitan Housing Authority	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Post Adoption Special Services Subsidy (PASSS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Prevention, Retention and Contingency (PRC)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Private health insurance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Social Security/Disability Insurance (SSI/SSDI)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Social Security Survivor's Benefits	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
State Adoption Maintenance Subsidy (SAMS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Supplemental Nutrition Assistance Program (SNAP)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
Temporary Assistance for Needy Families/ Case Asst.	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure

If you indicated yes to any of the above,
please provide detailed information about amounts and how funds have been used.

Physical and Behavioral Health History

Mental health and community services

Current Provider(s)

Service Name	Provider and Contact Name	Start Date	Last Visit

Previous Provider(s)

Service Name	Provider and Contact Name	Start Date	End Date

Does the Youth have a current DSM 5 Diagnosis? ☐ Yes ☐ No

Youth Diagnoses:

Medications:

Education

Financially Responsible School District: _____

Enrolled in School? ☐ Yes ☐ No

Start Date: _____ End Date: _____

District of Residence: _____ District of Attendance: _____

School Name: _____

Address: _____

_____

Street Address

_____

City *State* *ZIP Code*

Phone Number(s): _____

_____

Current Grade: _____ School Year:

_____ School Placement

☐ General Education ☐ Special Education

Is the youth on an IEP? ☐ Yes ☐ No

Does the youth have a 504 accommodation? ☐ Yes ☐ No

School Placement Type: _____

Are there attendance or truancy issues? ☐ Yes ☐ No

For Office Use Only

County Youth Identifier: _____