

**Please Note:**

**All Referrals for Service Coordination need to be sent to**

**Melissa J Rupp at**

**[mrupp@wmsco.org](mailto:mrupp@wmsco.org)**

**or by fax:**

**419-636-0643**

**Both pages of the Referral Form (with Release of information) must be completed and signed in order for a referral to be processed. A completed referral will be acted upon in two working days (office hours Monday through Thursday).**



## Service Coordination Referral Form

Date of Referral: \_\_\_\_\_ County: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 School District: \_\_\_\_\_ School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Child's Diagnoses: \_\_\_\_\_  
 Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Legal Custodian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Siblings in the home/ages: \_\_\_\_\_

Referring Agency: \_\_\_\_\_ Person Referring: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Reason(s) for referral:

- Child is age 0-21 and has multiple needs.
- Child/family is unable to access needed services.
- Child/family is experiencing a problem with coordination of existing services.
- Child is at-risk of being removed from his/her home or school.
- Child has been emergently removed from his/her home.

Presenting Issues/Safety Concerns: \_\_\_\_\_

Check all that apply:	Providers/Agencies	Contact Number
Children age 5 & under in the family?		
History of Alcohol or Drug Abuse? <input type="checkbox"/> Youth <input type="checkbox"/> Parent		
Involved in? <input type="checkbox"/> Juvenile Drug Court <input type="checkbox"/> Family Drug Court		
Mental Health Issues? <input type="checkbox"/> Child <input type="checkbox"/> Caregiver		
Family/Child(ren) involved in counseling?		
Physical/Sexual/Emotional Abuse Issues?		
Domestic Violence Issues?		
Placement Concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No Foster/Relative Provider:		
Housing Concerns?		
Educational Concerns? <input type="checkbox"/> Truancy <input type="checkbox"/> SED <input type="checkbox"/> On IEP <input type="checkbox"/> Expulsion		
Behavioral Concerns?		
Child Protective Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No Caseworker:		
Juvenile Court Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No Charges:		
Is client Medicaid eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		

OFFICE USE ONLY: Date Referral Received: \_\_\_\_\_

Service Coordinator's Checklist:	Reason for Referral:	Action Taken:
<input type="checkbox"/> Release of Information Signed?	<input type="checkbox"/> Service Coordination	<input type="checkbox"/> Information and Referral
<input type="checkbox"/> Parent Advocate Offered?	<input type="checkbox"/> Wraparound	<input type="checkbox"/> Service Coordination
<input type="checkbox"/> Parent Advocate Referral?		<input type="checkbox"/> Wraparound



### Informed Consent for Release & Exchange of Information

County: \_\_\_ Defiance \_\_\_ Fulton \_\_\_ Henry \_\_\_ Williams

I hereby give permission to release and exchange information regarding those individuals listed below for whom I have legal authority to act. The purpose of this release and exchange of information is referral to Family & Children First Council for service coordination.

Printed Name	Date of Birth

I hereby give permission to release or exchange information with the two following agencies for the purpose outlined above. Family & Children First Council contracts service coordination services from Four County Family Center, which is a separate service from their mental health services.

<input type="checkbox"/>	<b>Family and Children First Council: (circle one) Defiance – Fulton – Henry – Williams</b>
<input type="checkbox"/>	<b>Four County Family Center</b>
<input type="checkbox"/>	<b>Referring Agency:</b>

The following information may be released and exchanged. Please initial each line below.

\_\_\_ All case information, including but not limited to identifying information plus privileged health and medical information, social history, treatment/service history, psychological evaluations, IEP’s, transition plans, vocational assessments, grades and attendance, financial and parenting information, performance/attendance history and other personal information held by any of the above authorized agencies providers regarding those individuals listed above.

\_\_\_ Substance abuse diagnosis and treatment.

I understand I am under no obligation to sign this authorization form. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the information described. The information released is for professional purposes only. Only the minimum amount of information needed to achieve the stated purposes may be disclosed. Information may not be provided in whole or in part to any other agency, organization or person other than those stated above. I understand the Family Coordination Team in the county selected above and my Child & Family Team cannot guarantee the recipient will not disclose my health information to a third party, and that the recipient may not be subject to Federal laws governing privacy of health information. However, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the recipient is prohibited from re-disclosure under Federal law (42 CFR Part 2). See note below.

I understand I have 1) the right to revoke or restrict the authorization in writing at anytime and revocation will be effective except to the extent that certain actions reliant on my authorization have already been taken by the Family Coordination Team in the county selected above and/or my Child & Family Team, 2) the right to inspect or copy the health information to be used or disclosed, 3) the right to receive a copy of this authorization.

I have had the opportunity to review this informed consent form and understand its contents. By signing this informed consent form, I am confirming it accurately reflects my wishes. This authorization will remain in effect for 180 days, unless I revoke it in writing prior to the 180 day term.

Parent/Guardian Printed Name, Signature, Relationship to Child	Witness	Date
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I hereby **revoke** this authorization effective as of this date \_\_\_\_\_.

Parent/Guardian Printed Name, Signature, Relationship to Child	Witness	Date
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NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.