

Williams County Service Coordination and Resource Management Team Referral Form

Date of Referral: _____

Child's Name: _____ DOB: _____ Gender: M F

Address: _____ City _____ State _____ Zip _____

School District: _____

School Attending: _____ Grade: _____

Child Diagnoses: _____

Father: _____ Telephone: _____ hm _____ cell _____

Address: _____ City _____ State _____ Zip _____

Mother: _____ Telephone: _____ hm _____ cell _____

Address: _____ City _____ State _____ Zip _____

Legal Custodian (if not parent): _____ Telephone: _____

Address: _____ City _____ State _____ Zip _____

Siblings in the home/ages _____

Referring Agency: _____

Address: _____ City _____ State _____ Zip _____

Contact Person: _____ Telephone: _____

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: _____ Foster/Relative Provider: _____		
Housing Concern: _____		
Educational Concerns: <input type="checkbox"/> Truancy <input type="checkbox"/> SED <input type="checkbox"/> On IEP <input type="checkbox"/> Expulsion System		
Behavioral Concerns: _____		
Child Protective Involvement _____ Caseworker: _____		
Juvenile Court Involvement _____ Charges: _____		

Presenting Issues/Safety Concerns: (For Funding Requests, please specify specific service or equipment, amount of funding requested, unit rate, duration of services, provider of services, if known. If service provider is unknown, please state): _____

OFFICE USE ONLY:

Date Referral Received: _____

Serv. Coord. Checklist:	Reason for Referral:	Action Taken:	Child has/is:
Release of Information Signed?	Service Coordination	Service Coordination	Behavioral Health Dx
PRC Application Complete?	Funding	Resource Management Team	Medically Fragile
Parent Advocate Offered?	WrapAround	WrapAround	MRDD Eligible
Parent Advocate Referral?			
Sent to Council Coordinator?			

Agency Referral: _____ Issue Resolved: _____

Responsible Person: _____ Date of Action: _____