NEWDAY
YOUTH & FAMILY SERVICES

Date: _____

# New Day Wraparound Referral Form

## Young Person's Information

First Name: _____ Last Name: _____

Preferred name: _____ DOB: _____ Age: _____

Immigrant Status: ☐ U.S. Citizen ☐ Immigrant ☐ Refugee ☐ Asylum Seeker

Sex assigned at birth: ☐ Male ☐ Female

Gender young person identifies with: ☐ Cisgender Man ☐ Cisgender Woman ☐ Transgender Man ☐ Transgender Woman ☐ Gender Queer ☐ Not Listed: _____

Preferred Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

Sexual Orientation: ☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Asexual ☐ Not Listed: _____

Self-Identified Race (Check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Other: _____ ☐ Native Hawaiian/Other Pacific Islander ☐ Decline Race/Ethnicity ☐ American Indian/Alaskan Native

If American Indian/Alaskan Native, Tribal Affiliation: _____

Self-Identified Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Individual's First Language: _____ Language most comfortable communicating in: _____

Does the young person live at home? ☐ Yes ☐ No If "No" where does young person reside? _____

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

Best Contact Phone Number: _____ Can this # receive texts? ☐ Yes ☐ No

Email address: _____ Best way to contact young person: ☐ Email ☐ Call ☐ Text ☐ Facebook: _____

Does young person have insurance? ☐ Yes ☐ No If yes, what kind of insurance does the young person have? ☐ Medicaid ☐ Private Insurance

Name of Provider: _____

Pregnant or Parenting: ☐ Yes ☐ No How many children: _____

Due Date: _____

## Referral Source

**Referring Person:** _____ **Phone:** _____ **Email:** _____

**Relationship/Role:** _____

**Referring Agency:** _____

**Is CYFD the Legal Guardian?** ☐ Yes ☐ No **Is the Legal Guardian aware of this Referral?** ☐ Yes ☐ No

**(Name the CYFD Legal guardian on Pg. 3-Agency/System Involvement)**

***Strengths of Young Person:***

***Current challenges and areas that may need improvement:***

***Reason for Referral:***

## Family/Caregiver/Support Information

Legal Guardian 1: _____ Best Phone Number: _____ Can this # Receive Texts? ☐ Yes ☐ No

Relationship to Youth: _____ Language most comfortable communicating in: _____

Interpretation Services Needed? ☐ Yes ☐ No

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

Legal Guardian 2: _____ Best Phone Number: _____ Can this # Receive Texts? ☐ Yes ☐ No

Relationship to Youth: _____

Language most comfortable communicating in: _____

Interpretation Services Needed? ☐ Yes ☐ No

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

If CYFD is the Legal Guardian, are there contact restrictions with family members? ☐ Yes ☐ No

If Yes, Name: _____ Relationship: _____ Restriction: _____

**Please list those currently involved with the referred person (Family Members, Friends, Intimate Partners, Cultural Supports, Spiritual/Religious Supports, Mentors, School Staff, Attorneys, MCO Care Coordinator, CASAs, Treatment Provider, etc.)**

Name: _____ Relation: _____ Phone #: _____

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Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

## Agency/System Involvement

Is Young Person involved with CYFD? ☐ Yes ☐ No If "Yes" Which Service? ☐ PS ☐ JJS ☐ Transition ☐ CBHC

Name of CYFD Worker (PS/JPO/BHS): _____ County: _____ Contact Number: _____

Name of CYFD Worker (PS/JPO/BHS): _____ County: _____ Contact Number: _____

Check all the referrals young person is involved with: ☐ BH Provider ☐ School/Spec. Ed. ☐ Adult/Juvenile Court ☐ Other: _____

Has the young person been diagnosed with an SED or SMI diagnosis? ☐ Yes ☐ No

## Behavioral Health

| Young Person's Mental Health Diagnosis | Date of Diagnosis | Medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Education

Has the young person completed High School/GED? ☐ Yes ☐ No

If not, what is the highest grade they have passed in school? _____

Did or does young person have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

School most recently attended: _____

## INTERNAL USE ONLY - Criteria

1. Youth has a current diagnosis of SED or SMI? ☐ Yes ☐ No
   Is youth between the ages of 16-25 years old? ☐ Yes ☐ No

   If "Yes" to both then youth is HTEP Eligible, Proceed to #2

2. Multi-systemic Involvement (Please check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Child Protective Services | ☐ Yes | ☐ No | ☐ Historical | Juvenile Justice Services | ☐ Yes | ☐ No | ☐ Historical |
| Adult Protective Services | ☐ Yes | ☐ No | ☐ Historical | Behavioral Health Services | ☐ Yes | ☐ No | ☐ Historical |
| Special Education | ☐ Yes | ☐ No | ☐ Historical | | | | |

   If checked 2 or more systems, Proceed to #3

3. Functional Impairment (Please check the ones that is effecting the referred youth)

   ☐ Education ☐ Vocation ☐ Social ☐ Housing ☐ Legal ☐ Intellectual/Developmental

   If you checked at least 1, youth is Eligible for Wraparound.

Check the HTEP program youth is been directed to: ☐ Wraparound ☐ YPSS ☐ TARGET ☐ Other EBP's