Licking County Children and Families First Council
Service Coordination Referral

Return completed form to Melanie Fling, Multi-Systems Services Supervisor, at Melanie.Fling@jfs.ohio.gov , or fax-740-670-8992. Phone #-740-670-8916.

Child name (first and last): **Referral Date:**

Date of Birth: Gender: Age: Race:

Child's Address: Phone Number/Type (cell, work, home):

If over 18, is Youth living independently? ☐ Yes ☐ No

Custody/Adoption Status and start date:

Court Order, if Not Custody of Biological/Adoptive Parent? ☐ Yes ☐ No

Caregiver 1:

☐ Parent ☐ Guardian Name: Relationship:

Same as youth address? ☐ Yes ☐ No If no, address:

Email:

Phone Number if different from youth phone: #/Type: Phone 2#/Type:

Caregiver 1 has medical consent for youth? ☐ Yes ☐ No

Caregiver 2:

☐ Parent ☐ Guardian Name: Relationship:

Same as youth address? ☐ Yes ☐ No If no, address:

Email:

Phone Number if different from youth/Caregiver 1: #/Type: Phone 2#/Type:

Caregiver 2 has medical consent for youth? ☐ Yes ☐ No

Are translation services/other accommodations needed for youth/caregiver to support their involvement?

☐ Yes ☐ No If yes, language or type of accommodations:

Other family members in the home:

Who referred this youth/family?

Name: Agency:

Phone: Email:

What other agencies are involved in the care of the youth? (Provide name of Organization/provider)

Board of DD ☐
Early Intervention ☐
Home Visiting Program ☐
Mental Health/Addiction Services ☐
OOD ☐
Other

Child Protective Services ☐ Which county?
Juvenile Justice ☐
Physician/Hospital ☐
School District and name of school:
Does youth have an IEP? ☐ Yes ☐ No
Grade:
Teachers' Names:
Special Classroom: ☐ Yes ☐ No Explain:

Requested Meeting Participants	Agency/Role	Phone (P) or Fax (F) #

Who is the child's physician?

When was the child's last doctor's visit?

Has the child's vision been checked? ☐ Yes ☐ No

Has the child's hearing been checked? ☐ Yes ☐ No

What medical or emotional conditions the child currently being treated for?

List any medications which have been prescribed in the past year:

Does your child have allergies? ☐ Yes ☐ No Explain:

Has your child had any sleep or appetite disturbances? ☐ Yes ☐ No Explain:

Reasons for referral/events leading to this referral:

Brief History, including services and supports utilized to date:

Is the youth at risk of a residential placement? ☐ Yes ☐ No CANS score (if known):

Has the youth ever been in out-of-home placement? ☐ Yes ☐ No If yes, when and where:

Is the youth at risk for Truancy Court? ☐ Yes ☐ No List reasons for not attending school:

Has Consent and Release of Information been signed? ☐ Yes ☐ No Date signed:

Youth's Insurance Company Name/Type (Medicaid, Managed Care, Private Insurance):

Family size ____ Family's gross monthly income $_____(excluding child support)

How do you think the youth and family would benefit from a Community Support Team?

Desired outcome from participation in this program?

Additional information we should know as a part of this referral: