

Lorain County Children and Families First Council

Online Referral Form

Wraparound, Service Coordination and Consultation



REFERRING AGENCY INFORMATION

Referring Agency Name (If parent/guardian, please state that in "Title") _____

Referring Agency Contact Person Name _____ Title _____
First MI Last

Referring Agency Email _____ Referring Agency Phone _____

CHILD'S INFORMATION

Child's Full Name _____ If referrals are required for additional children, another form will need to be completed.
First MI Last

Child's Date of Birth _____ Child's Gender _____ Last 4 of Child's Social _____

Child's School District _____ Current School _____ Child's Grade _____

Current Placement

Home with parent(s)/guardian	Hospital-ER or Inpatient
Home with relative	Residential
Kinship	Respite
Foster	Homeless
Detention Center	Other _____

PARENT #1/GUARDIAN #1 INFORMATION

Full Name _____
First MI Last

Relationship _____ Custody _____

Email _____ Phone Number _____

Address _____
Street City State Zip

PARENT #2/GUARDIAN #2 INFORMATION

Full Name _____
First MI Last

Relationship _____ Custody _____

Email _____ Phone Number _____

Address _____
Street City State Zip

Additional Household Members (If none, write "not applicable") _____

Other Agencies Involved

Mental Health	Health Department
Job and Family Services	Children Services
Head Start	Special Education
Help Me Grow	Other _____
Juvenile Court	

Services Requested

Consultation

Service Coordination

High Fidelity Wraparound

Unknown at this time

Other _____

Provide a brief history of service needs

Is OhioRISE involved at this time? _____

K < 9 B 7 C A D @ H 9 8 Z D @ 5 G 9 ' 9 A 5 = @ H C .

7 : : 7 = B H 5 ? 9 4 @ C F 5 = B 7 C I B H M 1 G