SACRAMENTO COUNTY

FYRST High Fidelity Wraparound Referral

E-mail to: WrapReferrals@saccounty.gov

Referral Date: _____

CLIENT INFORMATION

Client Name: _____ **DOB**: _____ **Language:** _____ **SSN:** _____

Address:_____ **City and Zip:** _____ **Phone:** _____

Sex at Birth: _____ **Gender Identification:** Choose an Item

Caregiver Name: _____ **Language:** _____

Address: _____ **City and Zip:** _____ **Phone:** _____

Attorney Name: _____ **Phone:** _____

Type of Placement: Choose an Item

☐ **If placed outside** of Sacramento County, has a determination been made about Presumptive Transfer?

Referring SW/Probation/Caregiver: _____

Desk Phone: _____ **Cell Phone:** _____ **Email:** _____

Supervisor: _____

Desk Phone: _____ **Cell Phone:** _____ **Email:** _____

Case Type: Choose an Item **Specific Wrap Provider Request (optional):** _____

Documentation Required

Please verify these forms are on file with your agency: ☐ **JC\E-366** **and if on medication:** ☐ **JV-220**

Has a CFT been convened and the team agreed with the Wrap Referral? ☐ No ☐ Yes, Date: _____

If not, when will CFT be convened to discuss service options? Date: _____ **Do Not Leave Blank**

CLINICAL RATIONALE

ADDITIONAL DETAILS

Email form and attachments to WrapReferrals@saccounty.gov or fax to 916-854-8854, ATTN: WRAP Contract Monitor.

Incomplete referrals may delay the processing.