

CLIENT INFORMATION

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

Address: _____ City and Zip: _____ Phone: _____

Sex at Birth: _____ Gender Identification: _____

Caregiver Name: _____ Language: _____

Address: _____ City and Zip: _____ Phone: _____

Attorney Name: _____ Phone: _____

Type of Placement: _____

☐ 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: _____ Specific Wrap Provider Request (optional): _____

Previous mental health or ADS services?☐ Outpatient ☐ FIT ☐ TBS ☐ Full Service Partnership ☐ Wraparound ☐ TFC☐ Psychiatric Hospitalization ☐ ADS ☐ ERMHS ☐ None ☐ Other: _____**Current and active mental health or ADS services?**☐ Outpatient ☐ FIT ☐ TBS ☐ Full Service Partnership ☐ Wraparound ☐ TFC☐ Psychiatric Hospitalization ☐ ADS ☐ ERMHS ☐ None ☐ Other: _____**SCHOOL INFORMATION**

School: _____ Grade: _____ Ed Rights Holder: _____

Include JV-535 if available**MEDICAL INFORMATION**

Hospitalizations: _____ Hospitalization Details (in the last 2 years): _____

Current Psychotropic Medications: _____ If yes, attach **JV-220**Email form and attachments to WrapReferrals@sacounty.gov or fax to 916-854-8854, ATTN: WRAP Contract Monitor.***Incomplete referrals may delay the processing.***

Documentation Required

Please include with this referral form: ☐ JC\E-366 and if on medication: ☐ JV-220

Indicate which of the following additional documents you have attached:

☐ IEP ☐ Minute Order ☐ Probation Report ☐ Health/Education Passport Other: _____

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 FOR WRAPAROUND SERVICES (**REQUIRED**):

STRENGTHS (Required):

- | | | |
|---|---|--|
| <input type="checkbox"/> Access to transportation | <input type="checkbox"/> Good hygiene | <input type="checkbox"/> Is a leader |
| <input type="checkbox"/> Cares about animals | <input type="checkbox"/> Good connection to community | <input type="checkbox"/> Likes school |
| <input type="checkbox"/> Cares about others | <input type="checkbox"/> Has hobbies | <input type="checkbox"/> Placement stability |
| <input type="checkbox"/> Communicative | <input type="checkbox"/> Good sense of humor | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Has medical care | <input type="checkbox"/> Stable housing |
| <input type="checkbox"/> Creative | <input type="checkbox"/> Permanency plan | <input type="checkbox"/> Has friends |
| <input type="checkbox"/> Developmentally on track | <input type="checkbox"/> Physically healthy | |
| <input type="checkbox"/> Family involved | <input type="checkbox"/> Independent | |

CHALLENGES/NEEDS THAT INTERFERE WITH YOUTH'S QUALITY OF LIFE OR JEOPARDIZES PLACEMENT (Required):

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol or drug use issues | <input type="checkbox"/> Gang affiliation | <input type="checkbox"/> Poor attachment |
| <input type="checkbox"/> Preoccupied with anxiety | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Poor school attendance |
| <input type="checkbox"/> Assaultive | <input type="checkbox"/> Physical disability | <input type="checkbox"/> Parental mental health issues |
| <input type="checkbox"/> AWOLs | <input type="checkbox"/> Insecure housing | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Conflict with authority | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Refuses counseling |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Incarceration | <input type="checkbox"/> Self-Injury |
| <input type="checkbox"/> Depressed/withdrawn | <input type="checkbox"/> Isolated | <input type="checkbox"/> Shows no remorse |
| <input type="checkbox"/> Defies authority | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Sleep issues |
| <input type="checkbox"/> Death of significant person | <input type="checkbox"/> Limited family contact | <input type="checkbox"/> Suicidal talk/ideation |
| <input type="checkbox"/> Does not want reunification | <input type="checkbox"/> Medical care | <input type="checkbox"/> Temper/anger control |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Victimizes |
| <input type="checkbox"/> Multiple placements | <input type="checkbox"/> Neglect | <input type="checkbox"/> Violent crime witness |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Permanency | <input type="checkbox"/> 3+ placements in last 24 mos |
| <input type="checkbox"/> Poor nutrition habits | <input type="checkbox"/> Property damage | |
| <input type="checkbox"/> Follower | <input type="checkbox"/> History of physical abuse | |

ADDITIONAL DETAILS

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

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