St. Clair County Wraparound Referral

Child & Family Services, 2415 24th St., Port Huron, MI 48060
Attn: Jessica Moeller 810-488-8855 - jmoeller@scccmh.org
FAX: (810) 941-8833

Case #: _____

Date of Referral:	Referring Agency:
Referring Person:	Referring Person's Title:
Referring Person's Email:	Referring Person's Phone:
Referring Person's Address:	

Child's Name:	DOB:
Parent/Guardian 1:	Relationship:
Email:	Phone:
Parent/Guardian 2:	Relationship:
Email:	Phone:
Is the child a Temporary Court Ward (DHHS or Juvenile Probation) or MCI Ward?	
Worker:	
Email:	Phone:
Address:	
Worker:	
Email:	
Address:	

Living Arrangements

1. What is child's current placement? (i.e. bio home, foster care, family, etc.) _____
   _____
2. List names of all household members including referred child: _____
   _____

Name	*Relationship*	*Age*	*Grade*

Natural Supports

3. What natural supports does the family have? (These natural supports are individuals that can assist with the planning process, evaluation of interventions, and in some cases have a part in the implementation of the plan.)

Name	*Relationship*

4. Has the child been in foster care? Yes☐ No☐
5. Has the child been in a residential placement? Yes ☐ No☐
6. Child and family strengths: _____

_____

_____

_____

_____

Education

7. Is the child presently enrolled in school?
   a. If yes, current grade in school: _____
   b. Name of school: _____
   c. Does the child have an IEP: Yes ☐ No☐
   d. Does the child have 504: Yes ☐ No☐
   e. Does the child have a behavior plan: Yes ☐ No☐
   f. Has the child been truant in the last 6 months: Yes ☐ No☐
   g. Has the child been suspended or expelled from school: Yes☐ No☐
      Explain why and when: _____

Mental Health Services

8. List any services that the family/child has been involved with in the past:

Agency	Dates of Service	Type of Services

9. List any previous hospitalizations:

Hospital	Dates of Hospitalization	Reason

10. Does the child receive CMH service? Yes ☐ No☐
    If yes, who is the case-holder? _____
11. If no, where do they receive services? _____
    Are they willing to switch to CMH? Yes ☐ No☐
12. Has the child received wraparound services before? Yes ☐ No☐
13. Is the child prescribed any psychotropic medications? Yes ☐ No ☐
14. What is the child's current diagnosis? _____
15. Has the child been diagnosed with Autism? Yes ☐ No☐

Safety Indicators

In the last 90 days:

16. Has the child used drugs or alcohol? Yes ☐ No☐
    If yes, explain_____
17. Has the child physically hurt themselves on purpose? Yes ☐ No☐
    If yes, explain_____
18. Has the child made verbal statements about hurting themselves? **Yes** ☐ **No** ☐
    If yes, explain_____
19. Has the child physically hurt others on purpose? Yes ☐ No☐
    If yes, explain _____
20. Has the child attempted to run away from home? Yes ☐No☐
    If yes, how many times: _____
21. What is the child's current CAFAS/PECFAS score? _____

System Involvement

22. Identify current involvement with each of the following systems:

☐ DHHS ☐ Mental Health ☐ School ☐ Probation/J.J.

☐ Teen Health Center ☐ Friend of Court ☐ Police ☐ Other:

23. Explain involvement with probation/J.J. or police. _____
    _____
24. If on probation, who is the Probation Officer? _____
25. Has there been CPS involvement in the last 6 months? Yes ☐ No ☐

Summary/Expectations

26. Explain why you feel wraparound is needed and what you hope will be accomplished.