



Date and Time Received: _____
By Whom: _____
Referring Worker/Agency _____

WRAPAROUND MARYLAND REFERRAL

Identified Child:

Child's Name: _____

Race: _____ D.O. _____ Age: _____
 B.: _____

Social Security: _____	Insurance: _____	Private: _____ MA: _____
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Parent(s)/Guardian: _____

Address: _____ Telephone: (W) _____
 _____ (H) _____
 Youth Address: _____ (Cell) _____
 (if different) _____

Is the youth committed to and/or in the custody of DHR/DSS OR DJS?

Yes _____ No _____

Which Agency? _____

Who has medical guardianship of the youth?

Printed Name: _____

Risk Factors (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Abandonment
<input type="checkbox"/> Diagnosed Mental Illness
<input type="checkbox"/> Financial
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Death of Parent(s)
<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Promiscuity
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Housing
<input type="checkbox"/> Medical
<input type="checkbox"/> Emotional Disability
<input type="checkbox"/> Neglect
<input type="checkbox"/> Family Conflict
<input type="checkbox"/> Legal Issues/Incarceration
<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Delinquency | <input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Aggression/Assault
<input type="checkbox"/> Suicidal
<input type="checkbox"/> Prostitution
<input type="checkbox"/> Runaway
<input type="checkbox"/> School Problems
<input type="checkbox"/> Behavior Problems
<input type="checkbox"/> Learning Disability |
|---|---|--|

Explain checked indicators:

Referring Agency:

Brief History:

Desired Outcome from Wraparound Participation:

Current mental health services *(list agencies that have served this family)*:

Service Type	Provider Name and Contact Information	Frequency

**Please use additional sheets for other providers.*

Previous mental health services *(list agencies that have served this family)*:

Service Type	Provider Name and Contact Information	Frequency

By signing this agreement, I have indicated that I give the referring agency and wraparound staff permission to discuss this referral and to exchange written records as needed.

(Signature of Parent or Primary Caregiver)

Date

(Referring Agency*)

Phone Number for Referring Agency

(Signature of Referring Agency Representative*)

Date

For Care Coordinator Use

Date Received: _____

Initial Contact (must be within 3 days of receipt of referral):

Date: _____

Time: _____

Face to Face scheduled (must be within 7 days of referral):

Date: _____

Time: _____