

NM High-Fidelity Wraparound Referral Form

IN ORDER TO AID IN TIMELY REVIEW OF THIS REFERRAL, FORM SHOULD BE FILLED OUT COMPLETELY

Referral Source

Referring Agency

Referring Person:

Phone:

Email:

Is the Youth/Child referred aware of this referral? Yes No

Is the legal guardian aware of this referral? Yes No

If Language Interpretation is needed for any one below please list their names here and the language:

Information on Referred Child/Youth

Name:

Preferred Name:

Date of Birth:

Gender:

Self-Identified Ethnicity:

Preferred Language:

Current Address:

City:

State:

Zip Code:

Phone:

Does the child/youth have Medicaid? Yes No No If yes, MCO:

Legal Guardian (LG):

Phone #:

Is the LG CYFD-PS? Yes No If no, state relationship:

Parent/Caretaker Information

Parent/Caretaker 1 Name:

Parent/Caretaker 2 Name:

Phone: Text ok? Yes No

Phone: Text ok? Yes No

Address:

Address:

If not LG, can this person be contacted? Yes No

If not LG, can this person be contacted? Yes No

Supports

Please list those currently involved with the child/youth and family (Service Provider, School Staff, CYFD etc.)

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

System Involvement

Current or historic involvement with (please leave blank if unknown):

CYFD- Protective Services:	Current?	Yes	No	Historic?	Yes	No
CYFD - Juvenile Justice:	Current?	Yes	No	Historic?	Yes	No
Special Education Services:	Current?	Yes	No	Historic?	Yes	No
Behavioral Health Services:	Current?	Yes	No	Historic?	Yes	No

Reason for Referral - Check All Areas of Concern

Family Relationships	Emotional Stability	Substance Use	Housing Stability
School/Employment	Physical/Medical	Finances	Independent Living Skills
Social/Recreational	Developmental	Cognitive	Cultural
Interpersonal Relationships			

Please describe the behavior associated with the areas of concern checked above.

Supportive Documentation *Required

Collateral information is essential to making a timely determination on eligibility. Please check the documentation that is included with this referral :

*Comprehensive Assessment CANS/CAT Ed/Behavioral Intervention Plan Discharge Summary

Other: (Please use this space to explain if there is not a current Comprehensive Assessment)

For Administrative Use Only (to be completed by HFW Provider)

Date Referral Received Is the youth between the ages of 0-18? **Yes** **No**

Does youth meet SED eligibility criteria (Current/Historical)? **Yes** **No**

Does the youth have current or historic multi-systemic involvement in 2 of the 4 target systems or for ages 0-5 the child is at risk of multi-systemic involvement ? **Yes** **No**

Is function impairment in at least two domains documented in collateral and would be identifiable in a CANS? **Yes** **No**

If unchanged, will the youth's behavior and risks lead to out of home placement, or if in one will it lead to a prolonged out of home placement? **Yes** **No**

Reviewed by: Name:

Signature:

Date: