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| **NM High-Fidelity Wraparound Referral Form** |

**Form Must be Completed in Full**

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| **Referral Source** | | | | | | | | | | | |
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| **Referring Agency** |  | | |  |  |  | | | **Date:** |  | |
|  |  | | |  |  |  | | |  |  | |
| **Referring Person** |  | | |  | **Phone:** |  | | | **Email:** |  | |
| **Is the Referred person**  **involved with CYFD?** | | **Yes  No** | **Is CYFD the Legal Guardian**? | | | | **Yes  No** | **Is the Legal Guardian aware of this Referral?** | | | **Yes  No** |

(**Name the CYFD legal guardian on Pg. 3-Agency/System Involvement)**

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| **Information on Referred Individual** | | | | | | | | | | | | | | | | | | | | |
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| **First Name** | |  | | | | | | | |  | **Last Name** | |  | | | | | | |  |
| **Preferred Name?** | |  | | | | | | | |  | **Sex** | Male  Female  Other | | | | | | | | |
| **DOB** | |  | | | **AGE** |  | | | | **Self-Identified Ethnicity** | | | |  | | | | | |  |
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| **Individual’s First Language?** | | |  | | | | | | **Language most comfortable communicating in?** | | | | |  | | | | | |  |
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| **Does the Referral live at home?** | | | | **Yes  No** | | | | **If “No” where does individual Reside?** | | | | | | |  | | | | | |
| **Current Address** |  | | | | | | **City** | | |  | | | | **State** | | |  | **Zip** |  |  |
| **Best Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | **What MCO provider is individual covered under? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
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| **Caregiver’s Name**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | **Relation**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Contact Number**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Family/Caregiver/Support Information** |

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| **If CYFD is the Legal Guardian are there contact restrictions with family members?** | | | | | | | | | | | **Yes  No** | | | | | | | | | | | |  | | | | |
| **1-Parent’s Name** | |  | | | **Best Phone Number** | | | | | | |  | | | | | | | **Can this # Receive Texts?**  **Yes  No** | | | | | | | | |
|  | |  | | |  | | | | | | |  | | | | | | |  | | | | | | | | |
| **Language most comfortable communicating in?** | | | |  | | | | | | | | **Interpretation Servs. Needed?** | | | | | | | | | | | | **Yes  No** | | | |
|  | |  | | |  | | | | | | |  | | | | | | |  | | | | | | | | |
| **Current Address** | |  | | | | | | **City** | |  | | | | **State** | | |  | | | | | | **Zip** | | |  |  |
| **2-Parent’s Name** | |  | | | **Best Phone Number** | | | | | | |  | | | | | | | **Can this # Receive Texts?**  **Yes  No** | | | | | | | | |
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| **Language most comfortable communicating in?** | | | |  | | | | | | | | **Interpretation Servs. Needed?** | | | | | | | | | | | | **Yes  No** | | | |
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| **Current Address** | |  | | | | | | **City** | |  | | | | **State** | | | |  | | | | | **Zip** | | |  |  |
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| **Is Parent 1 a Legal Guardian?** | | | **Yes  No** | | | | **Is Parent 2 a Legal Guardian?** | | | | | | | | | | | **Yes  No** | | | | | | | | | |
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| **Please list those currently involved with the referred person**  **(Family, Attorneys, MCO Care Coordinator, CASAs, Treatment Provider, School Staff, etc.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name**  **Name** |  | | | | | **Relation** | | | |  | | |  | **Phone #**  **Phone #** | | | | | |  | | | | | | |  |
|  | | | | | **Relation** | | | |  | | |  | | | | | | |
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| **Name**  **Name** |  | | | | | **Relation**  **Relation** | | | |  | | |  | **Phone #**  **Phone #** | | | | | | | |  | | | | |  |
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| **Name**  **Name** |  | | | | | **Relation**  **Relation** | | | |  | | |  | **Phone #**  **Phone #** | | | | | | |  | | | | | |  |
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| **Name**  **Name** |  | | | | | **Relation**  **Relation** | | | |  | | |  | **Phone #**  **Phone #** | | | | | | |  | | | | | |  |
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| **Agency/System Involvement** | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Is Referred involved with CYFD?** | | | | |  | **Yes  No** | | | **If “Yes” Which Service** | | | |  | **PS  JJS  Transition  CBHC** | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Name of CYFD Worker (PS/JPO/BHS)** | |  | | | | | | **County** | |  | | | | | **Contact Number** | | |  |  |
|  | | | | | | | | | | | | | | | | | | | |
| **Name of CYFD Worker (PS/JPO/BHS)** | |  | | | | | | **County** | |  | | | | | **Contact Number** | | |  |  |
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| **Check all the Referred individual is involved with** | | | | | | | **BH Provider  School/Spec. Ed.  Adult/Juvenile Court  Other** | | | | | | | | | | | | |
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| **Has the Referral been diagnosed with an SED or SMI diagnosis? Yes  No** | | | | | | | | | | | | | | | | | | | |
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| **History of Services/Intervention-Newest to Oldest (For More Space Please use the Reverse Side)** | | | | | | | | | | | | | | | | | | | |
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| **Name of Provider** | | | | **Contact Number/Person** | | | | | | | | **Service/Type of Support** | | | | **Approximate Dates of Service** | | |  |
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|  | **(Use the back of this sheet if you need additional space)** | | | | | | | | | | | | | | | | | |  |

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| **Behavioral Health** |

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| **Referral’s Mental Health Diagnosis** | | | | | **Date of Diagnosis** | | | **Medication** | | | | |
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|  | **Please list concerning and at risk behavior** | | | | | | | | | | |  |
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| **Education** |

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| **Is referred person enrolled in school or employed?** | | **Yes  No** |  | **If in school, what**  **grade level?** |  | | | **If in school, does individual attend**  **If employed # of jobs in the last 12 months** | | | **Yes  No** |  |
| **Please list education History-Newest to Oldest (Use Reverse for Additional Space)** | | | | | | | | | | | | |
| **School** | | |  | **Dates Attended** | |  | **Contact Person** | |  | **Contact Phone** | |  |
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