New Alternatives Full Service Partnership Wraparound Referral Form

Program selection, referral information, eligibility, and consent

PROGRAM REQUESTED - CHECK ONE

- ☐ HFW - System Involved Referral
- ☐ HFW - Community Referral
- ☐ Intensive Care Management (ICM)

REFERRING PARTY INFORMATION

Date of Referral: _____ Agency/Organization: _____

Referring Party Name: _____ Relationship to Participant: _____

Phone: _____ Email: _____

PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____ Age: _____

Preferred Language: _____ Medi-Cal CIN/Member ID: _____

Address: _____

PARENT / LEGAL GUARDIAN INFORMATION

Name: _____ Relationship: _____

Phone: _____ Email: _____

ELIGIBILITY INDICATORS - CHECK ALL THAT APPLY

- ☐ Participant has full-scope Medi-Cal coverage.
- ☐ Participant is age 0-25 and meets age eligibility requirements.
- ☐ Risk of placement disruption or a change in living arrangement.
- ☐ Behavioral health crisis or psychiatric hospitalization history.
- ☐ Requires intensive care coordination across multiple systems or providers.
- ☐ Medi-Cal eligibility is pending verification.
- ☐ Significant emotional or behavioral health needs.

FAMILY AGREEMENT AND CONSENT

- ☐ The participant and/or legal guardian agree with this referral to HFW or ICM services.
- ☐ The participant and/or legal guardian agree to be contacted by New Alternatives regarding services.
- ☐ Verbal consent to share referral information with New Alternatives was obtained.

Name providing consent: _____ Relationship: _____ Date: _____

Final program eligibility is determined through New Alternatives intake review.

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Strengths, family context, concerns, and intake review

PARTICIPANT AND FAMILY STRENGTHS

Describe strengths, interests, supportive relationships, successful strategies, and what is working.

PARTICIPANT AND FAMILY DYNAMICS

Describe family relationships, living circumstances, cultural considerations, and important context.

CURRENT SERVICES AND SUPPORTS

List current providers, school supports, community resources, and natural supports.

SAFETY RISKS - CHECK ONLY THOSE THAT APPLY

- ☐ Suicidal ideation
- ☐ Suicide attempt history
- ☐ Self-harm behaviors
- ☐ Homicidal ideation
- ☐ Physical aggression toward others
- ☐ Property destruction
- ☐ Access to weapons
- ☐ Fire setting
- ☐ Sexualized behaviors
- ☐ Exploitation or unsafe relationship concerns

BEHAVIORAL RISKS

- ☐ AWOL/elopement
- ☐ Running away from placement/home
- ☐ School refusal/truancy
- ☐ Significant emotional dysregulation
- ☐ Severe temper outbursts
- ☐ Impulsivity/risk-taking behaviors
- ☐ Illegal activity
- ☐ Gang involvement

CLINICAL RISKS

- ☐ Depression
- ☐ Anxiety
- ☐ Trauma/PTSD symptoms
- ☐ Seeing/hearing things others do not
- ☐ Substance use
- ☐ Eating disorder concerns
- ☐ Difficulty taking prescribed medication
- ☐ Psychiatric hospitalization history
- ☐ Recent behavioral health crisis

FAMILY / SYSTEM RISKS

- ☐ Family conflict
- ☐ Domestic violence exposure
- ☐ Caregiver burnout
- ☐ Placement instability
- ☐ Risk of placement disruption
- ☐ Child welfare involvement
- ☐ Probation involvement
- ☐ Housing instability
- ☐ Lack of natural supports

DEVELOPMENTAL / EDUCATIONAL RISKS

- ☐ Developmental delays
- ☐ Regional Center involvement
- ☐ IEP/504 Plan
- ☐ Significant academic concerns
- ☐ Failing grades
- ☐ Suspensions or expulsions
- ☐ Employment/vocational concerns
- ☐ Independent living skills deficits
- ☐ Transition-age participant support needs

☐ Other risk factor(s):

REASON FOR REFERRAL / PRESENTING CONCERNS

Describe participant and family needs, current concerns, recent events, immediate safety concerns/plans, and why HFW or ICM support is being requested.

NEW ALTERNATIVES INTAKE USE ONLY

☐ Accepted ☐ Redirected ☐ Declined ☐ Pending Information ☐ Duplicate Referral Redirect to:

Date received: Reviewer: Decision Date:

Intake Notes: