ARKANSAS SYSTEM OF CARE (SOC) WRAPAROUND REFERRAL FORM
CHILD/ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)

Child's Name: SS#: Date of Referral:

Gender: ☐Male ☐Female Race: Date of Birth (Month/Date/Year): Age:

Address:
(Street or PO Box) (City) (State) (Zip Code)

Phone: (Home) (Cell) (Message)

County of Residence: Grade: School:

Parent(s)/Guardian(s) Name: Guardian, list relationship:

Child's native language: Parent(s) native language:

Interpreter needed: ☐Yes ☐ No Medicaid/ARKids 1st Eligible: ☐Yes ☐No Medicaid #: Private Insurance: ☐Yes ☐No

Child involved in mental health services: ☐Yes ☐ No: If yes, name of agency:

List child's mental health diagnosis/diagnoses (if any):

Child takes medication(s) for mental health issues:☐ Yes☐ No; If yes, name of medication(s):

Child receives Supplemental Security Income (SSI): ☐ Yes ☐No Child is certified Serious Emotionally Disturbed (SED): ☐Yes ☐No

PLEASE SELECT ALL OPTIONS BELOW THAT BEST DESCRIBE THE CHILD YOU ARE REFERRING: IF NONE OF THE OPTIONS DESCRIBES THE CHILD THEN CHECK "NOT APPLICABLE".

1) **High risk of out of home placement**
- ☐ Current out of home placement
- ☐ Previous out of home placement
- ☐ At risk for out of home placement*
- ☐ Not Applicable

2) **Suicide Ideas**
- ☐ Recent suicidal thoughts
- ☐ Previous suicidal thoughts
- ☐ Not Applicable

3) **Living Arrangements**
- ☐ Both parents (biological, step, adoptive)
- ☐ Single parent
- ☐ Relative: Specify: ______
- ☐ Out of home (foster care or non-relative)
- ☐ Not Applicable

4) **Homicidal Ideas**
- ☐ Current homicidal thoughts
- ☐ Previous homicidal thoughts
- ☐ Homicidal attempts
- ☐ Not Applicable

5) **Child is involved in:**
- ☐ Multiple school, church or community activities
- ☐ One extracurricular school activity, club or sport
- ☐ No activities outside of the home

6) **Substance abuse:**
- ☐ Current substance abuse
- ☐ Previous substance abuse
- ☐ Not Applicable

7) **Current Court Involvement**
- ☐ FINS
- ☐ Delinquency
- ☐ Custody/Adoption
- ☐ Protective Service/DCFS
- ☐ Diversion
- ☐ Not Applicable

8) **DCFS Involvement**
- ☐ Supportive Case
- ☐ Protective Service Case
- ☐ Foster Care
- ☐ Not Applicable

9) **Mental Health Hospitalizations (acute or short term)**
- ☐ 1 hospitalization
- ☐ 2 hospitalizations
- ☐ 3 or more hospitalizations
- ☐ Not Applicable

10) **When was the last acute or short term**
- ☐ Current or less than 30 days
- ☐ 2 to 3 months
- ☐ 4 to 6 months
- ☐ Longer than 6 months
- ☐ Not Applicable

11) **Residential Placement**
- ☐ Psychiatric: Number of Placements____
- ☐ Group Home Number of Placements____
- ☐ DYS Number of Placements____
- ☐ Not Applicable

12) **When was the last Residential Placement**
- ☐ Psychiatric: Current ☐ Months discharged____
- ☐ Group Home Current ☐ Months discharged____
- ☐ DYS Current ☐ Months discharged____
- ☐ Not Applicable

13) **School Behavior/Conduct**
- ☐ Office referrals/detention
- ☐ Out of school/ child day care suspension
- ☐ Expulsion from school or child day care
- ☐ Not Applicable

* Please describe the risk for out of home placement on next page

14) Special Education Needs
- ☐ 504 Behavior Plan
- ☐ IEP
  - ☐ Resource Classes
  - ☐ Self-Contained classroom
  - ☐ Inclusion
- ☐ Alternative School/Learning Environment

15) Academic Performance
- ☐ Above Satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Not in school

16) Sexual Activity
- ☐ Thinking about sexual things/looking at sexual material
- ☐ Child is sexually active
- ☐ Pregnant
- ☐ Child/Youth is a parent
- ☐ Not Applicable

17) Sexual Abuse (of referred child)
- ☐ Previous child abuse investigation
- ☐ Current child sexual abuse investigation
- ☐ Child abuse investigation is substantiated/founded
- ☐ Child has been placed in foster care
- ☐ Not Applicable

18) Sexual Perpetration (child as offender)
- ☐ Child is sexually acting out
- ☐ Child currently has pending charges for sexual crime
- ☐ Child has been convicted of a sexual crime
- ☐ Current/past investigation of sexual perpetration
- ☐ Not Applicable

19) Physical Abuse (of referred child)
- ☐ Previous child physical/neglect abuse investigation
- ☐ Current child abuse investigation
- ☐ Child abuse investigation is substantiated/founded
- ☐ Child has been placed in foster care
- ☐ Not Applicable

20) Physical Violence
- ☐ Child has been physically harmed in some way
- ☐ Child has witnessed physical harm of other person(s)
- ☐ Child has been bullied in school or community setting
- ☐ Not Applicable

21) Physical Aggression
- ☐ Past physical aggression
- ☐ Has bullied kids at school
- ☐ Has been involved in gang activity
- ☐ Current physical aggression
- ☐ Has been excluded from 1 or more community settings
- ☐ Not Applicable

What is the primary reason for referring this child/adolescent for a Wraparound?
Please list any medical or developmental concerns for the child/adolescent being referred:
Please describe the strengths of the child/adolescent and the family and any additional comments:
*Any additional information that would be helpful (Include any risk for out of home placement):

Name of person completing the referral:		**Relationship to child:**	
Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)
Phone: (Home/work):	**(Cell):**	**(Email):**	
Are you willing to participate in the Wrap/CASSP team meetings for this child/adolescent you are referring? ☐ **Yes** ☐ **No**			
Has family given permission to be referred for service? ☐ **Yes** ☐ **No**			
Please List any suggestion for Team members:			

For Office Use Only

Date Referral Received ___________ *Received by: ____________________*

Program Eligibility: AR CASSP ☐ *Yes* ☐ *No*

SOC Wraparound ☐ *Yes* ☐ *No*

External Referral Made: ☐ *Yes* ☐ *No* *To whom was referral made & date__________________*