

**REGION II HUMAN SERVICES  
YOUTH CARE COORDINATION  
REFERRAL FORM**

401 W. 1<sup>st</sup>  
Ogallala, NE 69153

PHONE: (308) 284-6767  
FAX: (308) 284-3084

**YOUTH INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Soc. Security # : \_\_\_\_\_ Language: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Language Preference: \_\_\_\_\_  
Is the youth a state ward? YES NO (If yes) Guardian Name: \_\_\_\_\_  
Current Diagnosis: Axis I \_\_\_\_\_  
Axis II \_\_\_\_\_  
Axis III \_\_\_\_\_  
Axis IV \_\_\_\_\_  
Axis V \_\_\_\_\_  
Current Mental Health Provider: \_\_\_\_\_

Is the youth at a high risk of becoming a state ward, committing a criminal offense, dropping or staying out of school or being placed out of the home? YES NO **If yes, please describe below:**

\_\_\_\_\_  
\_\_\_\_\_

Has the family agreed to referral and to participation in the wraparound process? YES NO

\_\_\_\_\_  
Signature of Referring Person Date  
\_\_\_\_\_  
Relationship Phone Number

**PROGRAM USE ONLY**

Assigned to: \_\_\_\_\_ Date Received: \_\_\_\_\_