Richland County Youth and Family Council Referral for Service Coordination

Referral Date: _____

Youth's First and Last Name:_____

Gender of Youth being referred: Male:_____ Female:_____ Transgender:_____

Race of Youth being referred: _____

Ethnicity (Circle Applicable): Not Hispanic/Latino, Hispanic/Latino, Other: _____

DOB: _____ **Age:** _____

Parent/Guardian Name: _____

Full Address: _____

Preferred Phone Number:_____

Source of Youth Referral:_____

Referral Agency, Email and Phone Number:_____

Other Agencies Involved: Team Members:
Name,Agency,Phone,Email:_____

Name,Agency,Phone,Email:_____

Name,Agency,Phone,Email:_____

Service Information:

Reason for Referral/Presenting Concern/Services being sought:

_____

_____

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By signing this form, you are consenting to allow personal health information to be entered into an Electronic Protected Health Information (EPHI) medical file, FidelityEHR. FidelityEHR follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, FidelityEHR protects against all unauthorized disclosures and manages compliance for all employees, contractors and vendors. Ohio Family and Children First Council (OFCFC) houses the Fidelity HER system for the Licking County Children and Families First Council. Your personal information will not be collected by OFCFC. Only demographic and non-personal identifying information will be collected by OFCFC for data analysis.

Parent or Guardian Signature: _____

Today's Date: _____