WAYPOINT
Help Along the Way

MANCHESTER SYSTEM OF CARE WRAPAROUND REFERRAL FORM

Please send this referral to Heather McQuade: mcquadeh@waypointnh.org or call 603-518-4000

Referrals are being accepted for children who are:

1. Medicaid eligible and reside in Manchester, NH
2. Between 0 and 8 years old
3. Have elevated score on a social emotional development screener (or are in a family with high risk factors)
4. Multi-service involved or are at risk of this (child and/or family)
5. Expressing that past/current services are ineffective or exceeds family ability to manage

Youth Information

First name:	Last name:	Date of birth:
Home address: City	State	Zip code

Caregiver information (parent/guardian/best person to contact about the referral)

First name:	Last name:	Prefer contact via: ☐ Email ☐ Phone
Email address:	Phone number:	Permission to: ☐ Call ☐Text
Relationship to youth:	Interpreter needed? ☐Yes ☐No	Language:

Referrer information

First name:	Last name:	Date of referral:
Email address:	Phone number:	Agency/organization:

Have you already spoken with the family about this referral? Yes☐ No☐ If so, with whom did you speak?

Primary reasons for referral: Please describe what the family is struggling with the most at this time.

In order to determine eligibility for wraparound, a Manchester SoC project manager will:

1. review this form
2. connect with referrer to discuss and review form
3. schedule an in-depth conversation with the youth/family about their needs and concerns
4. collect collateral information and communicate with other organizations as appropriate