



## MANCHESTER SYSTEM OF CARE WRAPAROUND REFERRAL FORM

Please send this referral to Heather McQuade: [mcquadeh@waypointnh.org](mailto:mcquadeh@waypointnh.org) or call 603-518-4000

Referrals are being accepted from families and providers for children and youth who:

1. Medicaid eligible and reside in Manchester, NH
2. Are between 0 and 8 years old
3. Have elevated score on a social emotional development screener
4. Are multi-service involved (child and/or family)
5. Past/current services 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: <input type="checkbox"/> Email <input type="checkbox"/> Phone
Email address:	Phone number:	Permission to: <input type="checkbox"/> Call <input type="checkbox"/> Text
Relationship to youth:	Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 reason for referral, what behaviors are you seeing?**

**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