



Nassau County Family Support System of Care Family Resource Center Referral Packet

The Family Resource Center is a family driven, youth guided program offering Wraparound Care Coordination, Family Support Groups, Youth Support Groups and Education Advocacy. We are not a mandated service, so families choose to participate based on their need and desire. Families can call the center directly to make an appointment. Additionally, to facilitate and support families in accessing our services, agencies may refer families directly to a Nassau County Family Support System of Care, Family Resource Center. When referring a family, please use the Family Resource Center Referral Form. Completed and signed forms can be faxed to 516-566-3959. Upon receiving the form, the Family Resource Center Intake Coordinator will make one outreach call to the family to set up an appointment. If contact is not made, a message will be left encouraging the family to contact the Family Resource Center. The Intake Coordinator will then email the identified Referring Worker to let him/her know the status of the referral. Below is the Eligibility Criteria.

Family Resource Center Eligibility Criteria

A child/youth eligible for participation in Nassau County Family Support System of Care must meet the following criteria:

- ☐ The youth is between the ages of 6 and 21
- ☐ The youth is experiencing difficulties at home, at school, or in the community for the past 6-12 months (or is expected to for the next 6-12 months)
- ☐ The youth is experiencing functional impairment in at least two of the following areas:
 - Family life
 - Self-care
 - Community
 - Social relationships
 - School performance
 - Self direction
- ☐ Youth is Diagnosed with Serious Emotional Disturbance
 - The youth has a recent mental health diagnosis (within the last year)

OR

- The youth does not currently have a mental health diagnosis (or the family is unsure), but the Pediatric Symptoms Checklist (PSC) or other screening tool indicates psychological impairment or concern
- ☐ Youth is currently receiving or is eligible to receive services in more than one child serving system





Nassau County Family Support System of Care Family Resource Center Referral Form

Date of Referral: _____ Program making referral: _____

Child's Name: _____ DOB: _____

Name of Parent or Guardian: _____

Address: _____

Phone: _____ Cell: _____ Work: _____

Name of Referring Worker: _____

Phone: _____ Email: _____

Reason for Referral (presenting problem):

Other Services working with family or family was referred to:

Does child have a Mental Health Diagnosis: ____yes ____no

If yes: Who made the Diagnosis: _____

Date of Last Assessment: _____ Diagnosis _____

Fax to: 516-566-3959 Attention: Intake Coordinator

I hereby grant permission to _____ to communicate with and release pertinent information to the Nassau County Family Support System of Care (*Families Together in New York State, Inc. and Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities*). I understand that a Nassau County Family Support System of Care staff member may contact me with information about their Family Resource Center.

Parent Signature: _____ Date: _____

For FRC Staff use:

Date Referral Received: _____ Date of Outreach Call: _____

Note: _____

Staff Initials: _____

