



Crawford County Family Navigators Referral Form



Date: _____

Demographic Information

Child's Name:		SS#:
Medical Assistance #:		Other Insurance:
Age:	Date of Birth:	Gender (choose one):
Parent/Guardian Name:		
Address:		
Relationship to Child:		Telephone:
Alternate Phone:		Email:
Household Members:		
Referred By:		Phone:
Referral Source:		
Current Living Situation:		

Is the family aware this referral is being made? ☐ Yes ☐ No

Reason for Referral

Please describe any emotional or behavioral health concerns you have observed in this child, youth, or young adult that you believe warrant further support or intervention.
In what ways have the child, youth, or young adult's emotional or behavioral challenges impacted their ability to function in key areas such as school, home, relationships, or daily routines?
Have there been instances where the child, youth, or young adult's emotional or behavioral health needs have significantly disrupted their well-being or required crisis-level support?
How long has the child, youth, or young adult been experiencing these emotional or behavioral challenges?
What strengths are known about the child, youth, or young adult?
What are the family's strengths?

Child, Youth, or Young Adult's and Family's Natural and Community Supports (if known)

School:	Grade:
Extended Family Members:	
Other Relationships:	
Community Involvement (sports, hobbies, clubs, activities, etc.):	

Current Treatment Team (if applicable)

PCP:	Phone:
MH Provider:	Phone:
Diagnosis:	

Other Systems Involved (JPO, CYS, FBMH, Therapist, etc.)

System	Contact Name	Contact Email

Out of Home Risk: ☐ none ☐ mild ☐ moderate ☐ imminent

Additional Helpful Information

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