



FCFC and Creative Options Options Case Manager

creativeoptions@guernseycountydd.org

P. 740-439-4451 ext.6847 F. 888-614-4042

60770 Southgate Road, Byesville, OH 43723

Guernsey County Creative Options Referral

Date:

Referral by: _____ Agency: _____

Phone: _____ Email: _____

Youth's Name	Date of Birth	Race	Gender

Adopted Biological Legal Custody of Family ECCS Temporary Custody of Family

Parent/Guardian Name:		
Relationship	Martial Status	Date of Birth
Address:		
City:	State:	Zip:
Employer:		
Home Phone:	Work phone:	Cell phone:
Email:		

Is the youth/child out of the home currently (hospital, detention, treatment or residential facility)?

Yes__ or No__ If yes, please enter date placed: ____

If yes complete the following:

Placement:		Contact:
Address:		Phone:
City:	Zip:	State:
Email:		
Other household members:	DOB:	Relationship:



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Professional Supports	Role	Phone (Ext)	Email Address
Name of Contact			
Children Services			
Juvenile Court			
Mental Health Provider			
Substance Abuse Treatment Provider			
Developmental Disabilities			
School			
Primary Care Provider			
Other Outside Support			
Natural Supports			

Additional Information

Yes No Is the Youth/Child currently enrolled in school? School Name _____ Grade _____

Yes No Does the Youth/Child have an IEP

Yes No Does the Youth/Child have a Developmental Disability or Development Delay.

Date of Diagnosis _____ Diagnosis provided by whom: _____

Diagnosis _____

Yes No Does the Youth/Child have a Mental Health Diagnosis.

Date of Diagnosis _____ Diagnosis provided by whom: _____

Diagnosis _____

Yes No Is an assessment scheduled? When/Where _____

Yes No Does the Youth/Child have pending charges in Juvenile Court?

Court Date _____ Charges _____ Probation Period _____

Yes No Are there current safety concerns? If so, please describe

Yes No Have there been other interventions/providers involved? If yes, explain



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Please give a detailed description for the referral:
(How can Creative Options help the family?)

Strengths

List positive attributes of the youth and family. Identify times when they were able to avoid situations that brought them to the system.

Characteristics: _____

Functional: _____

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_ Yes _ No Family was explained Creative Options services and wants to participate.

Guardian/Parent Signature: _____ Date: _____

PLEASE INCLUDE RELEASE FORM WITH THIS REFERRAL FORM

Revised 3/2024