

Referral Form

Referring Agent			
Caseworker (or name of referring individual):		Telephone:	
		Email:	
County office (or referring agency name):			Date:
Referral Source			
Check one.			
<input type="checkbox"/> DFCS-OFI/Food Stamps/Medicaid	<input type="checkbox"/> Faith-based Institutions	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Probation
<input type="checkbox"/> DFCS-Diversion	<input type="checkbox"/> Health Department	<input type="checkbox"/> Mental Health	<input type="checkbox"/> School
<input type="checkbox"/> DFCS-CPS	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other community agency	<input type="checkbox"/> Self
<input type="checkbox"/> DFCS-Placement Services	<input type="checkbox"/> Juvenile Court/Family Court	<input type="checkbox"/> Previous or current participant	<input type="checkbox"/> Shelter
<input type="checkbox"/> DFCS-Adoption Services			
Referral Information			
Agency/Program family is being referred to:			
Precipitating Factors:			
<input type="checkbox"/> Academic performance	<input type="checkbox"/> Crisis intervention	<input type="checkbox"/> Incarcerated parent	<input type="checkbox"/> Relative caregiver support
<input type="checkbox"/> Adoption/Guardianship	<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Job Skills	<input type="checkbox"/> School absenteeism/Truancy
<input type="checkbox"/> After school supervision	<input type="checkbox"/> GAL/CASA appointment	<input type="checkbox"/> Life Skills	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Child behavior	<input type="checkbox"/> Health and/or hygiene	<input type="checkbox"/> Mental Health Crisis	<input type="checkbox"/> Teen pregnancy
<input type="checkbox"/> Child development	<input type="checkbox"/> Homelessness	<input type="checkbox"/> Parenting Skills	<input type="checkbox"/> Visitation
Recommended Services (check all that apply):			
<input type="checkbox"/> Assessment and Follow-Up for Post-Placement Svcs	<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Peer Support Groups	
<input type="checkbox"/> Counseling	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Other:	
<input type="checkbox"/> Assessment previously completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of assessment: _____ Completed by: _____			
<input type="checkbox"/> Copy or summary of results of assessment attached			
Family Status			
<input type="checkbox"/> No Known CPS/DFCS involvement	<input type="checkbox"/> CPS Investigating	<input type="checkbox"/> Foster Care	
<input type="checkbox"/> DFCS OFI Only	<input type="checkbox"/> CPS Onoing/Family Preservation	<input type="checkbox"/> Foster Care Independent Living Program (ILP)	
<input type="checkbox"/> CPS Screen Out	<input type="checkbox"/> Closed CPS	<input type="checkbox"/> Pre- or Post-Adoptive Placement:	
<input type="checkbox"/> CPS Diversion	<input type="checkbox"/> Closed Placement (aftercare/follow-up)	(Placement Date: _____ ; Finalization Date: _____)	
Family Information			
Name of Primary Caregiver (should typically be identified as the <u>adult female</u> in the home):			List names of all individuals for whom services are requested:
Caregiver Type (select one):	Marital Status (select one):	Ethnicity (select one):	
<input type="checkbox"/> Biological Parent <input type="checkbox"/> Relative Caregiver <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Child-Placing Agency/Child-Caring Institution	<input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> African-American <input type="checkbox"/> American Indian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
Education (select one):			
<input type="checkbox"/> College Degree <input type="checkbox"/> Elementary 1-8 <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> Vocational			
Address (Street, City, State, Zip):			
County of Residence:		DFCS Case # (if applicable):	
Telephone:		Email:	
Contact instructions:			
Name of DFCS Worker:			County:
Worker's Phone:			Worker's Email:
<input type="checkbox"/> Family/individual is aware that this referral has been made and that the Service Provider will contact them directly.			
Additional Information About Child/Family/Placement Helpful For Service Provider To Know			
Follow Up Requested			
<input type="checkbox"/> Request follow-up documentation upon service completion. Instructions:			
<input type="checkbox"/> Request interim status reports. Instructions:			
Status of Referral. To be completed by service provider.			
<input type="checkbox"/> Attempts to contact family have been unsuccessful.	<input type="checkbox"/> Family contacted. Services can begin immediately.	Date referring agency notified of status:	
<input type="checkbox"/> Family contacted but declines services.	<input type="checkbox"/> Waitlisted for future services. Expected start date:		
Additional Comments:			