**Universal Referral Form for Services**

**Supervisory Review:**

Evaluation of Placement Risk:  Imminent Risk  Moderate Risk  Low Risk

FSOS/Chief Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Referral:**

**Program Desired (SSW/FSOS recommendation):**

CCC In-Home Based Services (IHBS) CCC Supervised Visitation CCC FTM

Family Preservation Programs–(ongoing case required)

Intensive Family Preservation Services Family Reunification Services Families and Children Safely Together

Intensive In-Home Services (Diversion)–(ongoing case required)

Preservation/Diversion  Reunification

Other- please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Reunification Services are being requested, attach a copy of the child’s Placement Summary.

Date of child’s initial removal:

Date that the child is expected to transition home:

**Case Name:**       **Case Number (required):**

**Family’s Address:**       **County:**

**Family’s Phone Number:**      **TANF Eligible (required):**  **Yes**  **No**

**Is the family aware that this referral is being made and given a description of each program?**  **Yes**  **No**

**Parent has signed a release form for CCC IHBS, FPP and IIHS (Diversion)?  Yes  No Date:**

(Note: All referrals require a signed release forms listing all providers for approval)

**Parent/guardian/caretakers:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **DOB** | **SS#** | **Relationship/Role** | **Willing to work with In-Home Services** | **TWIST Individual ID #**  **(required)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Children:** (indicate check under referred child if the child is at risk of placement or in need of reunification svc)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DOB** | **SS#** | **Gender** | **Referred child** | **TWIST Individual ID # (required)** | **Referred Child currently in home** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Other Household Members:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **DOB** | **SS#** | **Relationship/Role** | **To be involved with In- Home services** |
|  |  |  |  |  |
|  |  |  |  |  |

**If the caretaker/guardian listed above is not the parent please provide the information requested below.**

Mother:      Involved w/child?  Y  N Address:       Phone:

Father:       Involved w/child?  Y  N Address:       Phone:

**Reason for Referral:** (Explanation of situation/factors which places the child(ren) at risk of placement or resulted in the removal of the child(ren) from his parents’ care. Include behaviorally specific information about all individuals contributing to the risk of removals.) (For CCC IHBS- describe need for In-home services.)

**Services Needed:** (Referring worker’s recommended treatment goals or services to be provided by the in-home provider)

**Prior DCBS involvement:** (brief summary of number or prior referrals, the nature of those referrals and the findings. Include summary of prior ongoing cases and OOHC episodes)

**Presenting Problems: (what are the specific behaviors or issues that create risk for out-of-home placement ?) (CCC -need for in-home services) *\*Please check all that apply\** (double-click to check boxes if completing online)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Presenting Parent/Family Issues** | **Past** | **Present** | **Both** | **Comments**  **(Specify individual, severity, treatment, etc.)** |
| Alcohol Use – Parent |  |  |  |  |
| Divorce / Single Parent Issues |  |  |  |  |
| Domestic Violence |  |  |  |  |
| Drug Use – Parent |  |  |  |  |
| Mental Health Issues – Parent |  |  |  |  |
| Poor Parenting Skills |  |  |  |  |
| Criminal History – Parent |  |  |  |  |
| Limited Cognitive Functioning |  |  |  |  |
| Child Physical Abuse |  |  |  |  |
| Child Sexual Abuse |  |  |  |  |
| Child Neglect |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Presenting Child/ren Issues** | **Past** | **Present** | **Both** | **Comments**  **(Specify individual, severity, treatment, etc.)** |
| Aggression |  |  |  |  |
| Alcohol Use – Child |  |  |  |  |
| Behavior Problems at Home |  |  |  |  |
| Criminal Activity |  |  |  |  |
| Developmental Delays |  |  |  |  |
| Drug Use – Child |  |  |  |  |
| Gang Issues |  |  |  |  |
| Medication(s) |  |  |  |  |
| Mental Health Issues – Child |  |  |  |  |
| Pregnancy |  |  |  |  |
| Relative Placement |  |  |  |  |
| School Problems – Academic |  |  |  |  |
| School Problems – Behavioral |  |  |  |  |
| Self-Harm |  |  |  |  |
| Suicidal Ideation |  |  |  |  |
| Truancy |  |  |  |  |
| Child Physical Abuse |  |  |  |  |
| Child Sexual Abuse |  |  |  |  |
| Child Neglect |  |  |  |  |
| Other (please specify): |  |  |  |  |

* Are there mental health concerns of anyone in the home? If so, please explain
* Is there current or past court involvement (Abuse, Neglect, Dependency or Juvenile/Status) with the referred child/ren? If so, please explain.
* Are there other significant issues in the family? (medical problems, hearing impaired, mobility issues, etc)
* Identify family strengths.
* Are any of the following providers currently involved with this family and provide name of the provider/case manager.

Every Child Succeeds        First Steps

Impact        Impact Plus

Mental Health Provider        Other, specify

Department for Juvenile Justice (DJJ)

If DJJ is involved please provide an explanation of the type of type of involvement.

* Have any of the referred children received In-Home Services (CCC, FACTS, FPP, FRP or Diversion) services in the past?  Yes  No

If yes, please specify which child(ren), the month/year that those services ended and whether the program was completed before closure.

* **What is the intended plan if requested services not available?**        
  :
* DCBS worker’s assessment of the potential for physical violence:  
  Within the family: Extreme High Moderate Low None

Towards others: Extreme High Moderate Low None

**Referring Worker:**       **Email address:**      **Phone/ext:**

**Referring FSOS:**       **Email address:**      **Phone/ext:**

**Ongoing FSOS, if different:**       **Email address:**      **Phone/ext:**

If there is an FTM or other meeting scheduled to occur with this family you may include the date, time and location of the meeting here. If the referral is approved, the provider *may* attempt to participate in this meeting.

**Regional Office Use:**

**Approved, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Pending, end date: \_\_\_\_\_\_\_\_\_\_\_**  **Denied**

**Program Approved:**  **CCC In-Home Based Service (IHBS)**

**Family Preservation Program**

**Intensive In-Home Services (Diversion)**

**SSW/FSOS Notified of Approval Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral sent to Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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