



Referral Form

I am referring myself

Date: _____

I am submitting a referral on the behalf of the caregiver(s)

Agency Name: _____ Contact Name: _____
Phone Number: _____ Email: _____
Mandated Services Diversion Services

Caregiver(s) Name _____
DOB: mm-dd-yyyy _____ Marital Status _____
Partner Name: _____ Partner DOB: _____
Ethnicity: _____ Status Number: _____
Street Address _____ City _____
Phone Number _____ Text only? []

Reason for Referral: What do you feel a Family Support Worker could do for the family?

Household Information: Please list ALL individuals that are living in the home at the time of this application.
If you would like to indicate individuals not in the home, please indicate where they are residing in "other factors".

Table with 5 columns: Name, Age, Gender, Relationship to You, Other Factors

Pregnant? (Please Circle): Yes No Estimated due date? _____

Any pets in the home? (Please Circle): Cat Dog Other: _____

Does anyone smoke in the home? _____



What other community support is the family connected to?

Family Information:

Are you aware of any of the following topics? If so, please elaborate and indicate which family member(s) the area applies to. This information enables us to better match a Family Support Worker with your family. Please be assured that all information will be kept confidential.

Please Check if Applicable: Single Mom Teen Parent Grandparent Single Dad

Cognitive Limitations

(Circle: Child or Caregiver)

Fetal Alcohol Exposure

(Circle: Child or Caregiver)

ADHD

(Circle: Child or Caregiver)

Mental Health

(Circle: Child or Caregiver)

Autism Spectrum

(Circle: Child or Caregiver)

Health/Disability Concerns

(Circle: Child or Caregiver)

Alcohol Use

(Circle: past/current)

Drug Use

(Circle: past/current)

Intimate Partner Violence

(Circle: past/current)

Gang Affiliation

(Circle: past/current)

Incarceration

(Circle: past/current)

On the Methadone Program

No Contact Orders

Child Abuse

(Circle: Physical/Sexual/Emotional)

Child Neglect

(Circle: general/emotional/medical)

Physical Discipline

Lacks Parenting Skills

Yelling

School/Daycare attendance



- Children Running Away** _____
- Leaving Children Unsupervised** _____
- Inadequate Child Supervision** _____
- Child Behaviour** _____

- Home Cleanliness/Safety** _____
- Unstable/Inadequate Housing** _____
- Food Security** _____
- Budget/Income Struggles** _____
- Shared Custody** _____
- Child Protection Involvement**
(Circle: past/current) _____

Expected Outcomes:

Caregiver(s) Signature _____

MSS or Agency Signature (if applicable) _____

FOR MSS ONLY:

Please indicate the total hours of support expected per week: _____

Please check time frame to readdress contracted outcomes:

1 month 3 months 6 months Other: _____

Referrals can be emailed to:
programdirector@havenfamilyconnections.com
or
program@havenfamilyconnections.com