**Referral Form**

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| [ ]  I am referring myself Date: |   |

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

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| --- | --- | --- | --- | --- | --- |
|  Agency Name: |  |  Contact Name:  |  |  |  |
|   Phone Number: |  |  Email: |  |  |  |
|  |  |  |  |  |
|  |  [ ] Mandated Services [ ]  Diversion Services |  |
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| --- | --- | --- |
| 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?

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**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”.

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| **Name** | **Age** | **Gender** | **Relationship to You** | **Other Factors** |
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|  Pregnant? (Please Circle): Yes No |  |  |  Estimated due date?  |  |  |
|  Any pets in the home? (Please Circle): |  | No Cat Dog Other: |   |  |
|  Does anyone smoke in the home (Please Circle): Yes No |   |  |  |
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| What other community support is the family connected to?  |
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**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

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| [ ]  **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)* |  |
| [ ]  **Family 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)* |  |
| [ ]  **Inappropriate Discipline** |  |
| [ ]  **Lacks Parenting Skills** |  |
| [ ]  **Yelling** |  |
| [ ]  **School/Daycare attendance** |  |

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| --- | --- |
| [ ]  **Children Running Away** |  |
| [ ]  **Leaving Children Unsupervised** |  |
| [ ]  **Inadequate Child Supervision** |  |
| [ ]  **Child Behaviour** |  |

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

**Expected Outcomes:**

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Caregiver(s) Signature ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MSS or Agency Signature (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR MSS ONLY**:

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| Please indicate the total hours of support expected per week: |  |
| Please check time frame to readdress contracted outcomes:  [ ]  3 months [ ]  6 months  |  |

**Referrals can be emailed to:**

programdirector@havenfamilyconnections.com

or

program@havenfamilyconnections.com