**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: | |  |  | | |  |
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|  | 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)* |  | |
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| **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