

REQUEST FOR SERVICE

Date of receipt:	_/_	_/_	
Child First Staff Ini	tials:		

CHILD INFORMATION:								
Name (First / Last):			OOB:	/		Age:		
Gender:	□ M □ F □ unkno	wn						
Racial Origin: (check one)	☐ American Indian/Alaskan Native☐ Asian☐ Black/African-American☐ Native Hawaiian/Other Pacific Islander☐ White☐ Other							
Hispanic Origin:	☐ Hispanic ☐ Non-	•						
Client Insurance	☐ Husky A ☐ Hus	ky B 🔲 Private			□ U	nknown	☐ None	
CAREGIVER INFORMATION – Person(s) with whom child resides:								
1 st Caregiver Name	1st Caregiver Name: Age: Gender: □ Male □ Fem						e □ Female	
Relation to child:	🗅 biological parent 🚨 a	adoptive parent 🚨 foster pare	nt 🛭 relat	tive	· · · · · · · · · · · · · · · · · · ·	☐ other _	 	
2 nd Caregiver Name (optional): Age: _					Gende	er: 🛭 Male	e □ Female	
Relation to child:	🗅 biological parent 🚨 a	adoptive parent 🚨 foster pare	nt 🛭 relat	tive		☐ other _	 	
Street address:		Town/State	/Zip:					
Phone: (check prefe	Phone: (check preferred #) Home □: Mobile □: Work □:							
Best times to contact: ☐ 7-9am ☐ 9-12pm ☐ 12-5pm ☐ 6-9pm Email address:								
Is this the child's legal guardian? □ Y □ N □ unknown If no, name of legal guardian:								
Legal guardian contact information:								
Days & Hours avail	able for services: 🗖 N	И □T □W □Th □F // □	1 8 am – n	noon	□ noon	– 4 pm	□ 4-7 pm	
Is English spoken t	Is English spoken fluently by caregiver/guardian? □ yes □ no □ unknown Primary language:							
Do you have caregiver's permission to make referral? □ yes □ no If yes, □ written □ verbal □ both								
Do you have careg		•		-				
	iver's permission to n	•	If yes,	⊒ writte	en □ ve	rbal 🛭 b	oth	
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REFERRAL INFORMATION							
Please describe the concerns that have led to this referral: Please also indicate if referral is urgent and why.							
If DCF referral, please indicate status and goals.							
Reasons for Referral: (Check all that ap	(vla						
☐ Basic needs (e.g., housing, heat, food, TANF,	☐ Child abuse/neglect	☐ Parent/caregiver mental health					
SNAP, HUSKY)	☐ Risk of child out-of-home placement	☐ Parent/caregiver substance abuse					
☐ Child developmental/educational concerns☐ Child behavioral/emotional concerns	☐ Risk of child expulsion from school☐ Risk of family eviction	 □ Parent support and education needs □ Service coordination needs 					
☐ Child exposure to violence	☐ Major child/family health concerns	☐ Other (please specify):					
Other Services/Agencies Currently Invo	olved with Child/Family: (Check and	circle program if appropriate)					
☐ Birth to Three	☐ Early Childhood Consultation Partnership	,					
☐ Court personnel	(ECCP)	EHS, NFP)					
☐ Dept of Children and Families (DCF)	☐ Early childhood education/childcare	☐ Hospital – Emergency Room (ER)					
□ DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support	☐ Emergency Mobile Psychiatric Service (EMPS)	☐ Hospital – Obstetrics☐ Mental health provider - adult					
Team, other)	☐ Faith based organization	☐ Mental health provider - child					
□ DCF – Care Coordination	☐ Family resource & support center	☐ Regional Education Service Center (RESC)					
☐ Dept of Developmental Services (DDS)	☐ Health Department (WIC, Healthy Start)	☐ Shelter – family					
☐ Dept of Social Services (DSS) ☐ Dept Mental Health & Addiction Serv (DMHAS)	☐ Health provider – adult☐ Health provider – pediatric	□ School System – Special Education□ Substance abuse program					
☐ Domestic violence agency or shelter	☐ Help Me Grow	☐ Other					
Isent to the Child First affiliate agency, The Child Guidance	, legal guardian of e Center of Southern Connecticut, and for informatic	, give permission for this referral to be on to be sent to the Child First National Program Office. I					
understand that I will be contacted by the Child First affilia	ate agency directly to learn more about Child First ar	d if it is an appropriate service for my child and my family					
Legal guardian signature:		Date:					
Referrant signature:		Dare:					

PLEASE RETURN TO: Erica Pomerantz, PsyD Pomerae@chc1.com