DATE OF REFERRAL: _____/_____/_____

REQUEST FOR SERVICE

Date of receipt: ____/____/_____
Child First Staff Initials: _____

CHILD INFORMATION:

Name (First / Last):_____ **DOB:** _____/_____/_____ **Age:** _____

Gender: ❑ M ❑ F ❑ unknown

Racial Origin: (check one) ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African-American ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other

Hispanic Origin: ❑ Hispanic ❑ Non-Hispanic

Client Insurance ❑ Husky A ❑ Husky B ❑ Private _____ ❑ Unknown ❑ None

CAREGIVER INFORMATION – Person(s) with whom child resides:

1st Caregiver Name: _____ **Age:** _____ **Gender**: ❑ Male ❑ Female

Relation to child: ❑ biological parent ❑ adoptive parent ❑ foster parent ❑ relative _____ ❑ other _____

2nd Caregiver Name (optional): _____ **Age:** _____ **Gender**: ❑ Male ❑ Female

Relation to child: ❑ biological parent ❑ adoptive parent ❑ foster parent ❑ relative _____ ❑ other _____

Street address: _____ **Town/State/Zip:** _____

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 available for services: ❑ M ❑T ❑W ❑Th ❑F // ❑ 8 am – noon ❑ noon – 4 pm ❑ 4-7 pm

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

Has family previously been served by Child First? ❑ yes ❑ no ❑ unknown **If yes, when?** _____

Does child/family have history of DCF involvement? ❑ none ❑ yes, present ❑ yes, past ❑ unknown
If yes: ❑ CPS ❑ FAR ❑ unknown Name of FAR agency:_____

REFERRAL SOURCE INFORMATION

Name: _____ **Relation to caregiver/guardian:** _____

Name of agency:_____ **Position:** _____

Street address: _____**Town/State/Zip**: _____

Telephone: Office: _____ **Mobile:**_____ **Fax:** _____

Best times to contact: ❑ 7-9am ❑ 9-12pm ❑ 12-5pm ❑ 6-9pm **Email address:** _____

Type of Referral Source: ❑ Caregiver self-referral ❑ Relative

- ❑ Birth to Three
- ❑ Court personnel
- ❑ Dept of Children and Families (DCF)
- ❑ DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other _____)
- ❑ DCF – Care Coordination
- ❑ Dept of Developmental Services (DDS)
- ❑ Dept of Social Services (DSS)
- ❑ Dept Mental Health & Addiction Serv (DMHAS)
- ❑ Domestic violence agency or shelter
- ❑ Early Childhood Consultation Partnership (ECCP)
- ❑ Early childhood education/childcare
- ❑ Emergency Mobile Psychiatric Service (EMPS)
- ❑ Faith based organization
- ❑ Family resource & support center
- ❑ Health Department (WIC, Healthy Start)
- ❑ Health provider – adult
- ❑ Health provider – pediatric
- ❑ Help Me Grow
- ❑ Home visiting (Nurturing Family, PAT, EHS, NFP)
- ❑ Hospital – Emergency Room (ER)
- ❑ Hospital – Obstetrics
- ❑ Mental health provider - adult
- ❑ Mental health provider - child
- ❑ Regional Education Service Center (RESC)
- ❑ School System
- ❑ Shelter - family
- ❑ Substance abuse program
- ❑ Other_____

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.

_____

_____

_____

_____

_____

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_____

_____

Reasons for Referral: (Check all that apply)

- ❒ Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY)
- ❒ Child developmental/educational concerns
- ❒ Child behavioral/emotional concerns
- ❒ Child exposure to violence
- ❒ Child abuse/neglect
- ❒ Risk of child out-of-home placement
- ❒ Risk of child expulsion from school
- ❒ Risk of family eviction
- ❒ Major child/family health concerns
- ❒ Parent/caregiver mental health
- ❒ Parent/caregiver substance abuse
- ❒ Parent support and education needs
- ❒ Service coordination needs
- ❒ Other (please specify):_____

Other Services/Agencies Currently Involved with Child/Family: (Check and circle program if appropriate)

- ❑ Birth to Three
- ❑ Court personnel
- ❑ Dept of Children and Families (DCF)
- ❑ DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other _____)
- ❑ DCF – Care Coordination
- ❑ Dept of Developmental Services (DDS)
- ❑ Dept of Social Services (DSS)
- ❑ Dept Mental Health & Addiction Serv (DMHAS)
- ❑ Domestic violence agency or shelter
- ❑ Early Childhood Consultation Partnership (ECCP)
- ❑ Early childhood education/childcare
- ❑ Emergency Mobile Psychiatric Service (EMPS)
- ❑ Faith based organization
- ❑ Family resource & support center
- ❑ Health Department (WIC, Healthy Start)
- ❑ Health provider – adult
- ❑ Health provider – pediatric
- ❑ Help Me Grow
- ❑ Home visiting (Nurturing Family, PAT, EHS, NFP)
- ❑ Hospital – Emergency Room (ER)
- ❑ Hospital – Obstetrics
- ❑ Mental health provider - adult
- ❑ Mental health provider - child
- ❑ Regional Education Service Center (RESC)
- ❑ Shelter – family
- ❑ School System – Special Education
- ❑ Substance abuse program
- ❑ Other_____

I _____ , legal guardian of _____ , give permission for this referral to be sent to the Child First affiliate agency, The Child Guidance Center of Southern Connecticut, and for information to be sent to the Child First National Program Office. I understand that I will be contacted by the Child First affiliate agency directly to learn more about Child First and if it is an appropriate service for my child and my family.

Legal guardian signature: _____ Date:_____

Referrant signature: _____ Dare:_____

PLEASE ATTACH THE CHILD FIRST CONSENT FOR SERVICES, OR YOUR AGENCY'S SIGNED RELEASE OF INFORMATION FORM

PLEASE RETURN TO: Kate Murphy, LCSW at murphyka@chc1.com