REQUEST FOR SERVICE

Date: ____/_____/_____

CHILD INFORMATION:

Name (First / Last):____ **DOB:** _____/_____/_______ **Age:** __________

Gender: ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ Other ________________

Racial Origin: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African-American
(check one) ❑ 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**: ❑ M ❑ F ❑ T ❑ NB

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

2nd Caregiver Name (optional): ______________________________ **Age:** ________ **Gender**: ❑ M ❑ F ❑ T ❑ NB

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___________________________

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)
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❑ 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____________________________

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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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: Child First Assistant Director Christina Miller, LCSW at millerch@chc1.com