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| **Referral Date:** | Click or tap here to enter text. | **County of residence:** | Click or tap here to enter text. |

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| Primary Caregiver Name: | Click or tap here to enter text. | [ ]  Check box if self-referral |
| Address: *(Note Apt. or Unit #)* | Click or tap here to enter text. |  |
| City/Town: | Click or tap here to enter text. | **State & Zip Code:** | Click or tap here to enter text. |
| Gender: | Click or tap here to enter text. | **Telephone:** | Click or tap here to enter text. |
| Race/Ethnicity: | Click or tap here to enter text. | **Preferred Language:**  | Click or tap here to enter text. |

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| **Referral Source/Contact Information**  |
| [ ]  **Social Service Staff** | [ ]  DCP&P Caseworker/Supervisor, Office: Click or tap here to enter text. Phone number & E-mail: Click or tap here to enter text.[ ]  Other: Click or tap here to enter text. |
| [ ]  **Community** | [ ]  Mental Health Care Provider: Click or tap here to enter text.[ ]  Pediatrician: Click or tap here to enter text.[ ]  School/ Childcare: Click or tap here to enter text.[ ]  Other community agency: Click or tap here to enter text. |
| [ ]  **Obtained Verbal consent from the Parent/Caregiver** |

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| **Children**Last Name/ First Name | DOB/ Age | Gender | Race/Ethnicity | Relationship to Primary Caregiver |
| Click or tap here to enter text.  |       /       |       |       |       |
| Click or tap here to enter text. |       /       |       |       |       |
| Click or tap here to enter text. |       /       |       |       |       |
| Click or tap here to enter text. |       /       |       |       |       |

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| **Other Adults** Last Name/ First Name | DOB/ Age | Gender | Race/Ethnicity | Relationship to primary caregiver | In homeY/N? |
| Click or tap here to enter text. |       /       |       |       |       |       |
| Click or tap here to enter text. |       /       |       |       |       |       |
| Click or tap here to enter text. |       /       |       |       |       |       |

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| **Reason for referral and/or desired outcome:**  Click or tap here to enter text. |
|  |
| *For Internal Office Use Only:*  |
| **Reviewed by Gatekeeper:** |       |       |       |       |
| *Name* | *Title* | *Telephone* | *State E-mail* |
| Individual and Family Assessment (Case Plan)  | Attached       |
| Disposition | [ ]  Family declined Date:       | [ ]  Referral accepted Date:       |
|  | [ ]  Referral denied Date:       |