Family Service OF THE PIEDMONT + child first

REQUEST FOR SERVICE

***DATE OF REQUEST FOR SERVICE:** _____/_____/_____ Child First Staff Initials: _____

Asterisk (*) denotes fields that are always required in CFCR. Additional fields may be required based on data entry.

RFS INFORMATION

PERSON MAKING REQUEST FOR SERVICE

***Last Name:** _____ ***First Name:** _____

***Telephone:** _____

***REFERRAL SOURCE:**

- ❑ Self (Caregiver or family)
- ❑ FSOP (Specify program: _____)
- ❑ Court personnel
- ❑ Child welfare/Child Protective Services
- ❑ Child developmental services provider
- ❑ Children's Advocacy Center
- ❑ Domestic violence agency or shelter
- ❑ Early Head Start
- ❑ Early childcare provider/partnership
- ❑ Faith-based organization
- ❑ Family resource & support center
- ❑ Health provider – Obstetric/adult
- ❑ Health provider – Pediatric
- ❑ Hospital/NICU
- ❑ Mental health provider – Adult
- ❑ Mental health provider – Child
- ❑ Home visiting program (Specify: _____)
- ❑ Public health service/department
- ❑ School system
- ❑ Shelter (Specify type of shelter: _____)
- ❑ Social services
- ❑ Substance abuse program
- ❑ Other_____

CHILD REFERRED FOR SERVICES:

***Last Name:** _____ *First Name: _____

***Address:** _____

***Phone:** _____

***Child DOB:** _____/ _____ / _____ (MM DD YYYY)

***Gender:** ❑ Male ❑ Female

***Child Race:**

- ❑ Black or African-American
- ❑ White/Caucasian
- ❑ Asian
- ❑ American Indian/Alaskan Native
- ❑ Native Hawaiian/Pacific Islander
- ❑ Multiple/Multiracial
- ❑ Unknown/Did not report

***Child Ethnicity:**

- ❑ Non-Hispanic, Non-Latino, Not of Spanish Origin
- ❑ Non-Hispanic – Caribbean
- ❑ Non-Hispanic – Haitian
- ❑ Hispanic – Cuban
- ❑ Hispanic – Mexican (or Mexican American, Chicano)
- ❑ Hispanic – Puerto Rican
- ❑ Hispanic – South or Central American
- ❑ Hispanic – Other
- ❑ Unknown

***Language:**

- ❑ English
- ❑ Spanish
- ❑ Portuguese
- ❑ French creole
- ❑ Other, please specify: _____

***Child insurance status:**

- ❑ Amerihealth
- ❑ Health Choice
- ❑ Healthy Blue
- ❑ Medicaid Direct
- ❑ Private insurance
- ❑ Wellcare
- ❑ United Healthcare Community
- ❑ No medical insurance coverage
- ❑ Unknown

ADULT TO BE INVOLVED IN SERVICES

***Is the adult to be involved in services the same person as above? (Person making referral)** ❑ Yes ❑ No

If 'No':

***Name:** _____

***Address:** _____

_____

***Phone:** _____

***Relation to child:** ❑ Birth Father ❑ Birth Mother ❑ Foster Mother ❑ Foster Father ❑ Step Mother ❑Step Father ❑Adoptive Mother ❑Adoptive Father ❑Female Relative (e.g. grandma, aunt) ❑Male Relative (e.g. grandpa, uncle) ❑Unrelated female adult ❑Unrelated male adult ❑Mother's live-in partner ❑Father's live-in partner ❑Other

ADDRESS FOR HOME VISITS

Will the home visits take place at the child's physical address in CFCR?

❑ Yes ❑ No ❑ Unknown at this time

If 'No,' enter the address below.

Address for Home Visits (different from Child's physical address in CFCR)

Address: _____

_____

REASONS FOR RFS

REASONS FOR REFERRAL: (Check all that apply)

- ❒ Basic needs (e.g. housing, heat, food, clothing)
- ❒ Child developmental/educational concerns
- ❒ Child behavioral/emotional concerns at home
- ❒ Child behavioral/emotional concerns at school or child care
- ❒ Child exposure to domestic violence
- ❒ Child exposure to community violence
- ❒ Child abuse/neglect
- ❒ Need for parenting education
- ❒ Imminent risk of or recent out-of-home placement
- ❒ Risk of or recent child expulsion from child care or school
- ❒ Homelessness or risk of family eviction
- ❒ Major child/family health concerns
- ❒ Parent/caregiver mental health concerns
- ❒ Parent/caregiver substance abuse
- ❒ Parent/caregiver educational needs
- ❒ Service coordination needs
- ❒ Referral source did not identify a reason
- ❒ None/none listed
- ❒ *Other (please describe) _____

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY: (Check all that apply)

- ❑ Court personnel
- ❑ Child welfare – Investigation
- ❑ Child welfare – Alternative services
- ❑ Public support services (e.g. Social services, developmental services)
- ❑ Public health services
- ❑ Domestic violence agency or shelter
- ❑ Early childhood education/childcare
- ❑ Faith-based organization
- ❑ Family resource & support center
- ❑ Health provider – Adult
- ❑ Health provider – Pediatric
- ❑ Home visiting (Healthy Start, Parents as Teachers, Nurse Family Partnerships)
- ❑ Hospital – Emergency Room (ER)
- ❑ Hospital – Obstetrics
- ❑ Mental health provider - Adult
- ❑ Mental health provider - Child
- ❑ Mobile Crisis
- ❑ Shelter – Family
- ❑ Substance abuse program
- ❑ None/none listed
- ❑ *Other (please describe) _____

REASONS FOR REFERRAL NARRATIVE:

Please include events that led to the referral, other agencies involved with the family and relevant family dynamics not captured above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

I _____, legal guardian of _____, give permission for this referral to be sent to Family Service of the Piedmont, Inc. 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:_____

Referent signature: _____

Date:_____