# Community Based Prevention, Intervention and Reunification Services Referral

Please provide as much detail as possible, and include all required attachments. If this is a CYFD referral, include copies of the most recent safety assessment, risk assessment, CARA plan, and current safety plan, if applicable. If an area does not apply to a family, put N/A. Any missing information may delay the scheduling of a warm hand-off.

**1. Referring Partner Information:**

Date: _____ Employee Name/Title: _____Referring Agency:_____

Phone Number: _____Email Address: _____

**2. Family's Information:**

Primary Caregiver Name: _____ DOB: _____

Personal Phone #: _____Email Address: _____ Relationship to Child(ren) _____

Address/Directions

Secondary Caregiver Name: _____DOB:_____

Personal Phone #:_____ Relationship to Child(ren): _____

Address/Directions

**Are biological parents involved in this referral?** ☐Yes ☐No **If not, please give information on where Biological parent(s) reside and their involvement with their child:**

FACTS # (If known) _____ Family's Primary Language: _____

FCM Scheduled? ☐Yes ☐No If yes, Date_____ Location_____

Court Date Scheduled? ☐Yes ☐No If yes, Date_____ Location_____

Is this a youth services referral? ☐Yes ☐No Is the family aware that this referral was made? ☐Yes ☐No

**Please list all adults living in household whom the program will work with (use another sheet if necessary)**:

| First Name | Last Name | Date of Birth | Relationship |
|---|---|---|---|
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**Please list all children living in household whom the program will work with:**

| First Name | Last Name | Date of Birth | Biological mother | Biological father |
|---|---|---|---|---|
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Reason for referral/Summary of Family's Situation/CYFD recommendations:

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Supports available to the family (family members, friends, other service providers working w/ family, etc.)

| Family Support | Relationship | Contact Information |
|---|---|---|
| | | |
| | | |
| | | |

CYFD History (# of prior reports, Type of abuse or neglect, Substantiated or Unsubstantiated, Allegations if applicable):

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|---|
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**FOR CYFD ONLY: COMPLETE THIS SECTION IF THE CHILDREN ARE IN CYFD CUSTODY**

**Are any of the children in CYFD Custody? ☐Yes ☐No** If **yes**, date of custody: _____

Trial Home Visit Date: _____ Transition Calendar **☐Yes ☐No** If **yes**, please attach to referral.

Foster Parent Name: _____Foster Parent Phone: _____

Reason for Custody:

| |
|---|
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**For Reunification services attach the following to the referral—any missing information will delay the scheduling of a warm hand-off.**

☐Affidavit
☐Most recent Bio-Psycho-Social Assessment
☐Most recent treatment plan

**I certify that the referral was discussed with the family and that the information on this form was completed to the best of my knowledge:**

**Agency Employee Signature _____Date_____**

**For the community-based agency only**

**Date referral received: _____ Date of Warm Handoff: _____**