DATE OF REFERRAL: _____/_____/_______

Intercommunity Inc.
E. Hartford/Manchester
REQUEST FOR SERVICE

Date assigned: ____/____/_____
Date opened: ___/___/______
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

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

Name: ______________________________________ **Age:** ________ **Gender**: ❑ Male ❑ Female
(First) (Last)

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

Is this the child's legal guardian? ❑ Y ❑ N ❑ unknown **If no, name of legal guardian:** ___________________

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:** _________________________

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)
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- ❑ 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 ____ 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 RETURN TO:

Alaina Crawford
alainacrawford@intercommunityct.org
fax: 860-291-1396