

PHILLIPS' FAMILY PARTNERS

Programs for Children and Families

7010 Braddock Road

Annandale, VA 22003

Phone: (703) 658-9054 Fax: (703) 658-9056

Contact: Sandy Porteous, MA, Program Coordinator

Please return referral form to: Susie.Quinn@phillipsprograms.org

Date of Referral: _____

Name of Referring Worker _____

Agency: _____

Phone Number _____ Fax Number: _____

Address: _____

County: _____ City: _____ State: _____ Zip: _____

Is the case Medicaid? ____ Yes ____ No If yes, please give Medicaid #: _____

Has the family been approved by FAPT/CAT? ____ Yes ____ No

Will this be mandated or non-mandated funds? _____

How many hours have been approved? _____

What services were approved? ____ Home-based ____ Therapy ____ Mentoring

____ In-home respite ____ Out of home respite

____ Supervised Visitation

Has the family been informed that you are referring them to Family Partners? ____ Yes ____ No

FAMILY

Family Name: _____

Address where child is currently living: _____

County: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

IDENTIFIED CHILD'S/CHILDREN'S NAME	DATE OF BIRTH	M/F	SOCIAL SECURITY NUMBER

Where is the child(ren) living now?: (please check one)

- | | |
|---|--|
| <input type="checkbox"/> At home with Parent/Guardian | <input type="checkbox"/> Diagnostic Group Home |
| <input type="checkbox"/> Relatives Home (informal) | <input type="checkbox"/> Detention Center |
| <input type="checkbox"/> Relatives Home (foster home) | <input type="checkbox"/> Less Secure Facility |
| <input type="checkbox"/> Non-Relatives Home (informal) | <input type="checkbox"/> Corrections Center |
| <input type="checkbox"/> Adoptive Home (foster child prior) | <input type="checkbox"/> Residential Placement |
| <input type="checkbox"/> Regular Foster Home | <input type="checkbox"/> Psychiatric hospital |
| <input type="checkbox"/> Therapeutic Foster Home | <input type="checkbox"/> Temporary / Emergency Shelter |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Unknown |

PARENT / LEGAL GUARDIAN			
NAME	DATE OF BIRTH	RELATIONSHIP TO CHILD	M/F

Marital Status of parent(s) of guardian(s): _____

Ethnicity of Family: _____

Is the identified child/children living with the parent/legal guardian? ____ Yes ____ No

If child/children is not living with parent/legal guardian, with whom are they living? _____

If child's address is different than parent/legal guardian, please list:

Address: _____

1. Please describe the events that led up to this referral: _____

2. Please describe any family history that relates to present events: _____

3. Please describe the child's legal history, if any (probation status, criminal charges, etc.): _____

4. Please list problems that you believe contribute to the situation (e.g. substance abuse, truancy, etc.):

5. Please list the strengths of the family: _____

6. What changes does the family have to make in order for the child(ren) to remain in the home: _____

7. Please explain any safety issues that may impact our work with the family: _____

8. What services does the family receive (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> CPS | <input type="checkbox"/> Big Brothers / Sisters / Mentor |
| <input type="checkbox"/> Department of Social Services | <input type="checkbox"/> Court Based Services (Probation) |
| <input type="checkbox"/> Family Counseling / Therapy | <input type="checkbox"/> Outpatient Counseling / Psychotherapy |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> Inpatient Psychiatric Treatment |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Day Treatment |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Alcohol or Drug Treatment |
| <input type="checkbox"/> Runaway Support Program | <input type="checkbox"/> Self-Help or Support Group (AA) |
| <input type="checkbox"/> Psycho Educational Group | <input type="checkbox"/> Residential Treatment |
| <input type="checkbox"/> Other | |

(Signature of person taking Referral information)

(Date)