CHILD WELFARE REFERRAL FORM									
REFERRAL SOURCE									
Referral Date: FSFN Case #	FSFN F	Person ID:	FSFN Case Type: Select FSFN Case Type						
Person Referring:	Agency:		Service Center:						
Phone:	Email	:	<del></del>						
Supervisor:	Phone:	Email:							
CLIENT INFORMATION									
First:	Middle:		Last:						
SSN:	DOB:		Gender: ☐ Female ☐ Male						
Marital Status:	Race:		Ethnicity:						
Client/Caregiver Phone:		Client/Caregiver Email	· · · · · · · · · · · · · · · · · · ·						
Address:	City:	Zip:	County:						
Current Caregiver:	Relationship:		rdian, if not Caregiver:						
	-								
Language Preference:	`	gnant? □No □ Yes	If yes, Date Due:						
Medicaid Plan:	Medicaid #:		her Health Insurance #:						
Other Health Insurance Name:		Other Health Insuranc	e Phone:						
	PRESENT	ING PROBLEM							
If you are requesting an <b>evaluation</b> , please be	specific about what you	u hope to learn. If you are re	questing a <b>service</b> , please list what issue(s) or						
	SERVICE	SERVICE REQUESTED							
Section I: Assessment and Evaluation Servi	<u>ces</u>	пасовоты							
☐Psychiatric Evaluation			ment						
□Mental Health Assessment		☐ Medication Manager ☐ Anger Management							
□Substance Abuse Assessment		☐ Medication Manager ☐ Anger Management ☐ Batterer's Intervent	(Group) ion Program (BIP) - Intake, Asmt. & Orient.						
□Psychological Evaluation		☐ Medication Manager ☐ Anger Management ☐ Batterer's Intervent	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group)						
		☐ Medication Manager ☐ Anger Management ☐ Batterer's Intervent ☐ Batterer's Intervent  Section III: Additiona	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) <u>ll Services</u>						
□ Neuropsychological Evaluation		☐ Medication Manager ☐ Anger Management ☐ Batterer's Intervent ☐ Batterer's Intervent  Section III: Additiona ☐ Behavior Analyst As	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) <u>Il <b>Services</b></u> sessment						
□Psychological Evaluation with IQ and Achie	vement	☐ Medication Manager ☐ Anger Management ☐ Batterer's Intervent ☐ Batterer's Intervent  Section III: Additiona ☐ Behavior Analyst As ☐ Behavior Analyst Sec	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions - □ BCBA or □ BCaBA						
□Psychological Evaluation with IQ and Achie □Psychosexual Evaluation	vement	□ Medication Manager □ Anger Management □ Batterer's Intervent □ Batterer's Intervent  Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Sec	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions - □ BCBA or □ BCaBA Iltional or □ Therapeutic						
□ Psychological Evaluation with IQ and Achie □ Psychosexual Evaluation □ Attachment/Bonding Assessment	vement	□ Medication Manager □ Anger Management □ Batterer's Intervent □ Batterer's Intervent  Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Security □ Mentoring - □ Trade □ Parenting Group (>1)	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions -  BCBA or  BCaBA litional or  Therapeutic I Participant/Class Setting)						
☐ Psychological Evaluation with IQ and Achie☐ Psychosexual Evaluation☐ Attachment/Bonding Assessment☐ Evaluation Addendum	vement	□ Medication Manager □ Anger Management □ Batterer's Intervent: □ Batterer's Intervent:  Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Security □ Mentoring - □ Trade □ Parenting Group (>1 □ Parent/Adolescent (	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions - □ BCBA or □ BCaBA Iitional or □ Therapeutic Il Participant/Class Setting) Coaching						
□ Psychological Evaluation with IQ and Achie □ Psychosexual Evaluation □ Attachment/Bonding Assessment □ Evaluation Addendum  Section II: Therapy Services		□ Medication Manager □ Anger Management □ Batterer's Intervent □ Batterer's Intervent  Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Secundary Intervent □ Parenting Group (>1 □ Parent/Adolescent Government	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions - □ BCBA or □ BCaBA Ilitional or □ Therapeutic Il Participant/Class Setting) Coaching - □ Substance Abuse or □ Paternity						
□ Psychological Evaluation with IQ and Achie □ Psychosexual Evaluation □ Attachment/Bonding Assessment □ Evaluation Addendum  Section II: Therapy Services □ Mental Health Counseling Intake, to include		□ Medication Manager □ Anger Management □ Batterer's Intervents ■ Betterer's Intervents ■ Betterer's Intervents ■ Behavior Analyst As □ Behavior Analyst Second III: Additional III: Addition	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions -  BCBA or  BCaBA Ilitional or  Therapeutic I Participant/Class Setting) Coaching -  Substance Abuse or  Paternity gement						
□ Psychological Evaluation with IQ and Achie □ Psychosexual Evaluation □ Attachment/Bonding Assessment □ Evaluation Addendum  Section II: Therapy Services □ Mental Health Counseling Intake, to include □ Individual Therapy		□ Medication Manager □ Anger Management □ Batterer's Intervent □ Batterer's Intervent  Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Sec □ Mentoring - □ Trad □ Parenting Group (>1 □ Parent/Adolescent Coordinates and Coo	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions -  BCBA or  BCaBA Ilitional or  Therapeutic I Participant/Class Setting) Coaching -  Substance Abuse or  Paternity gement						
☐ Psychological Evaluation with IQ and Achie ☐ Psychosexual Evaluation ☐ Attachment/Bonding Assessment ☐ Evaluation Addendum  Section II: Therapy Services ☐ Mental Health Counseling Intake, to include ☐ Individual Therapy ☐ Group Therapy		□ Medication Manager □ Anger Management □ Batterer's Intervent □ Batterer's Intervent Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Sec □ Mentoring - □ Trad □ Parenting Group (>1 □ Parent/Adolescent Cook □ Laboratory Testing - □ Targeted Case Mana □ Translation Services □ Tutoring	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group)  Il Services sessment ssions - □ BCBA or □ BCaBA litional or □ Therapeutic Il Participant/Class Setting) Coaching - □ Substance Abuse or □ Paternity gement						
☐ Psychological Evaluation with IQ and Achie ☐ Psychosexual Evaluation ☐ Attachment/Bonding Assessment ☐ Evaluation Addendum  Section II: Therapy Services ☐ Mental Health Counseling Intake, to include ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy	Treatment Plan	□ Medication Manager □ Anger Management □ Batterer's Intervent: □ Batterer's Intervent: ■ Section III: Additiona □ Behavior Analyst As □ Behavior Analyst Section III: Additiona □ Parenting Group (>1 □ Parent/Adolescent Cook Intervent: □ Laboratory Testing □ Targeted Case Mana □ Translation Services □ Tutoring □ Medical Education S	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions -  BCBA or  BCaBA litional or  Therapeutic 1 Participant/Class Setting) Coaching -  Substance Abuse or  Paternity gement services (In Home) -  RN or  LPN						
☐ Psychological Evaluation with IQ and Achie ☐ Psychosexual Evaluation ☐ Attachment/Bonding Assessment ☐ Evaluation Addendum  Section II: Therapy Services ☐ Mental Health Counseling Intake, to include ☐ Individual Therapy ☐ Group Therapy	Treatment Plan	□ Medication Manager □ Anger Management □ Batterer's Intervents ■ Betterer's Intervents ■ Behavior Analyst As □ Behavior Analyst Second Mentoring - □ Trade □ Parenting Group (>100 □ Parent/Adolescent Coording = □ Translation Services □ Tutoring □ Medical Education S □ Personal Care/Resp	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions - □ BCBA or □ BCaBA litional or □ Therapeutic I Participant/Class Setting) Coaching - □ Substance Abuse or □ Paternity gement icervices (In Home) - □ RN or □ LPN ite Services						
☐ Psychological Evaluation with IQ and Achie ☐ Psychosexual Evaluation ☐ Attachment/Bonding Assessment ☐ Evaluation Addendum  Section II: Therapy Services ☐ Mental Health Counseling Intake, to include ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Specialized Therapy (Type: Sexual Abuse, Paragraps)	Treatment Plan	□ Medication Manager □ Anger Management □ Batterer's Intervents □ Betterer's Intervents ■ Behavior Analyst As □ Behavior Analyst Second III: Additiona □ Behavior Analyst Second □ Trade □ Parenting Group (>1 □ Parent/Adolescent Coording □ Targeted Case Manae □ Translation Services □ Tutoring □ Medical Education Society □ Intensive In Home Medical Education Intensive In Home Intensive Int	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group) Il Services sessment ssions -  BCBA or  BCaBA litional or  Therapeutic 1 Participant/Class Setting) Coaching -  Substance Abuse or  Paternity gement services (In Home) -  RN or  LPN						
□ Psychological Evaluation with IQ and Achie □ Psychosexual Evaluation □ Attachment/Bonding Assessment □ Evaluation Addendum  Section II: Therapy Services □ Mental Health Counseling Intake, to include □ Individual Therapy □ Group Therapy □ Family Therapy □ Specialized Therapy (Type: Sexual Abuse, Fair List Type:	Treatment Plan	□ Medication Manager □ Anger Management □ Batterer's Intervents □ Betterer's Intervents ■ Behavior Analyst As □ Behavior Analyst Second III: Additiona □ Behavior Analyst Second □ Trade □ Parenting Group (>1 □ Parent/Adolescent Coording □ Targeted Case Manae □ Translation Services □ Tutoring □ Medical Education Society □ Intensive In Home Medical Education Intensive In Home Intensive Int	(Group) ion Program (BIP) - Intake, Asmt. & Orient. ion Program (Group)  Il Services sessment ssions - □ BCBA or □ BCaBA litional or □ Therapeutic Il Participant/Class Setting) Coaching - □ Substance Abuse or □ Paternity gement services (In Home) - □ RN or □ LPN ite Services Medical Services (RN or Higher)						

Provider Name:		PROVIDER	INFORMAT	ION			
Family Functioning Assessment (FFA) Initial & Ongoing   Shelter Order   Case Plan	Provider Name: Phone	e:		Email:			
Previous Evals.   Previous Treatment Records   CBHA   Other, List:   Collateral Contacts   Name:   Phone:   Relationship:   Collateral Contacts   Name:   Phone:   Relationship:   Relationship:   Collateral Contacts   Name:   Phone:   Relationship:   Re	*IMPORTANT* REFERRAL DOC	CUMENTATION '	TO FOLLOW (	(EMAIL TO PROVIDER) *IMPORTANT*			
Collateral Contacts: Name:	□Family Functioning Assessment (FFA) Initial & Or	ngoing 🗆 Shelt	er Order 🛚 C	ase Plan 🔲 Judicial Reviews 🗆 Education Records			
MENTALHEALTH AND SUBSTANCE ABUSE HISTORY	$\square$ Previous Evals. $\square$ Previous Treatment Records	□CBHA □Oth	ner, List:				
MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY  Current Diagnosis[es]:  Type of Drug(s) Using: Date Drug Tested: Positive Results: Provider/Program  Medication (Mental Health) Inpatient Hospitalization/Detox/Baker Act Other, List:  INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)  Household Size (incl. participant): Page Relationship  Name Age Relationship  Name Age Relationship  Number of Children Living In: Home: Residential: Shelter: Homeless: Other: List Other: Resultential: Active Case Plan Gal is Reunification: Press   No   Provider/Program  With Relative: With Priend: Positive Requirements for Children Removed from Home: Active Case Plan Gal is Reunification: Press   No   Provider/Program  Pr	Collateral Contacts: Name:	Phone:		Relationship:			
Current Diagnosis(es):  Type of Drug(s) Using:    Date Prog Tested:	Collateral Contacts: Name:	Phone:		Relationship:			
Type of Drug(s) Using:    Date Drug Tested:	MENTALHI	EALTH AND S	UBSTANCE	ABUSE HISTORY			
Date Drug Tested:	Current Diagnosis(es):						
Positive Results:	Type of Drug(s) Using:						
Type of Services  Current Past Provider/Program  Outpatient Counseling  Medication (Mental Health) Inpatient Hospitalization/Detox/Baker Act  Other, List:  INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)  Household Size (incl. participant): # Adults: # Children:  Name Age Relationship  Number of Children Living In: Home: Foster Care: With Relative: With Friend: Residential: Shelter: Homeless: Other: List Other: Requirements for Children Removed from Home: Active Case Plan Goal is Reunification:   See   No   **If no, then client is not eligible for TANF services  A Copy of Gase Plan is Attached to Referral:   See   No   See   See	Date Drug Tested:		Results:	☐Positive ☐ Negative			
Outpatient Counseling  Medication (Mental Health) Inpatient Hospitalization/Detox/Baker Act Other, List:  INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)  Household Size (incl. participant): # Adults: # Children:  Name	Positive Results:     THC   AMP   MET	□PCP □COC	- □OPI □Oth	ner, List:			
Medication (Mental Health) Inpatient Hospitalization/Detox/Baker Act Other, List:    INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)	Type of Services	Current	Past	Provider/Program			
Inpatient Hospitalization / Detox/Baker Act Other, List:    INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)   Household Size (incl. participant):	Outpatient Counseling						
INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)   Household Size (incl. participant):	Medication (Mental Health)						
INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)   Household Size (incl. participant):	Inpatient Hospitalization/Detox/Baker Act						
Name Age Relationship  Name Age Relationship  Number of Children Living In: Home: Foster Care: With Relative: With Friend: Residential: Shelter: Homeless: Other: List Other: Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification: Yes   No	Other, List:						
Name Age Relationship  Name Age Relationship  Number of Children Living In: Home: Foster Care: With Relative: With Friend: Residential: Shelter: Homeless: Other: List Other: Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification: Yes   No	INFORMATION FOR TANF REF	FERRALS ONLY (	REQUIRED FO	OR ADULTS WITH MH/SA SERVICES)			
Number of Children Living In: Home: Foster Care: With Relative: With Friend:  Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:   Yes   No							
Number of Children Living In: Home: Foster Care: With Relative: With Friend:  Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:   Yes   No		Age		Relationship			
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:	1,1,000						
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Residential: Shelter: Homeless: Other: List Other:  Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:							
Requirements for Children Removed from Home:  Active Case Plan Goal is Reunification:	Number of Children Living In: Home:	Foster (	Care:	With Relative: With Friend:			
Active Case Plan Goal is Reunification:   Yes   No   **If no, then client is not eligible for TANF services  A Copy of Case Plan is Attached to Referral:   Yes   No    If Case Plan is Not Available, Please Explain:    TO BE COMPLETED BY ALL PROVIDERS    Date Referral Received:   Approved   Denied   Next Appt. Date:     Reason for Denial:   Income above Guidelines   Incomplete Information   Other (specify in comments)     Date Referral Receipt Notification Sent by Email Back to Referral Source   AND referrals@cbccfl.org:     Comments:   Comments   Comments   Comments     Comments   Comments   Comments   Comments   Comments     Comments   Comments   Comments   Comments   Comments     Comments   Comments   Comments   Comments   Comments     Comments   Comments   Comments   Comments   Comments     Comments   Comments   Comments   Comments   Comments   Comments   Comments     Comments   Co	Residential: Shelter: Home	eless:	Other:	List Other:			
A Copy of Case Plan is Attached to Referral:							
TO BE COMPLETED BY ALL PROVIDERS  Date Referral Received:							
Date Referral Received: Approved Denied Next Appt. Date:  Reason for Denial: Income above Guidelines Incomplete Information Other (specify in comments)  Date Referral Receipt Notification Sent by Email Back to Referral Source AND referrals@cbccfl.org:  Comments:	A Copy of Case Plan is Attached to Referral: □Yes □ No						
Date Referral Received:  Reason for Denial:  Date Referral Receipt Notification Sent by Email Back to Referral Source AND referrals@cbccfl.org:  Comments:	If Case Plan is Not Available, Please Explain:						
Date Referral Received:  Reason for Denial:  Date Referral Receipt Notification Sent by Email Back to Referral Source AND referrals@cbccfl.org:  Comments:			ID DU ALL DD	OVER THE STATE OF			
Reason for Denial:   Income above Guidelines   Incomplete Information  Other (specify in comments)  Date Referral Receipt Notification Sent by Email Back to Referral Source  AND referrals@cbccfl.org:  Comments:							
Date Referral Receipt Notification Sent by Email Back to Referral Source AND referrals@cbccfl.org:  Comments:							
Comments:							
Printed Name of Staff Phone Email							
Printed Name of Staff Phone Email							
Printed Name of Staff Phone Email							
Printed Name of Staff Phone Email							
PLEASE SEND COMPLETED ASSESSMENT(S) OR MONTHLY SERVICE SUMMARY REPORT(S) ONGOING TO REFERRAL SOURCE							