

FACES

FAMILY ADVOCACY, CARE, EDUCATION, SUPPORT

HOME VISITATION REFERRAL FORM

CLIENT/FAMILY INFORMATION	DATE: _____	/ RECEIVED By FACES: _____
Last Name	First Name	
Address	City	Zip County
Home Phone	Cell Phone	Business/Other Phone

HOUSEHOLD MEMBERS (List all below for people living in the home)					<i>Enter codes from menu below</i>		
	Last Name	First Name	Sex	DOB	Race	ED	EMP
Mother							
Father							
Partner							
			Relationship				
Child							
Child							
Child							
Child							
Child							
Other							
Other							

FAMILY STATUS (check all that apply)

1 <input type="checkbox"/> Single	5 <input type="checkbox"/> Foster Care
2 <input type="checkbox"/> Married	6 <input type="checkbox"/> Kinship Family
3 <input type="checkbox"/> Living With	7 <input type="checkbox"/> Dev. Delayed Parent
4 <input type="checkbox"/> Separated	8 <input type="checkbox"/> Dev. Delayed Child

REASON FOR REFERRAL (check all that apply)

<p>Primary</p> <p>1 <input type="checkbox"/> 1ST Time Parent</p> <p>2 <input type="checkbox"/> Isolated</p> <p>3 <input type="checkbox"/> Parent Ed</p>	<p>Secondary</p> <p>1 <input type="checkbox"/> Domestic Violence</p> <p>2 <input type="checkbox"/> Homeless/Shelter</p> <p>3 <input type="checkbox"/> Drug/Alcohol</p> <p>4 <input type="checkbox"/> History of Child Abuse</p> <p>5 <input type="checkbox"/> Other _____</p>	<p>Tertiary</p> <p>1 <input type="checkbox"/> Previous Child Protection Involvement</p> <p>2 <input type="checkbox"/> Abuse/Neglect Occurring</p>
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SERVICE REQUESTED (check all that apply)

1 <input type="checkbox"/> Individual Counseling
2 <input type="checkbox"/> Couple Counseling
3 <input type="checkbox"/> Family Counseling
4 <input type="checkbox"/> Child-Centered Counseling
5 <input type="checkbox"/> Parent Education

CODE MENU

Racial/Ethnic Codes

A African American
 B Anglo
 C Asian
 D Bi/Multi Racial
 E Latino
 F Native American
 G Other _____

Education Codes

A Master/Graduate
 B Bachelor
 C Some College
 D High School Grad/GED
 E Some High School
 F 8th Grade or Less

Employment Codes

A Full-Time Employed
 B Part-Time Employed
 C Student
 D Unemployed

REFERRAL SOURCE/INFORMATION	OFFICE USE ONLY
Agency Name: _____	Case ID#: _____
Name/Title: _____	Previous Client: _____
Phone Number: _____	Assigned To: _____
Address: _____	1 st Visit: _____

Reason for Referral: Please provide a brief narrative that addresses your specific (concrete) reason for referral, areas of concern, personality traits of parents and children, family dynamics observed, abuse and neglect issues and strengths you have identified. (Please attach a second sheet if necessary.)

ANNUAL HOUSEHOLD INCOME:

- | | | | | | |
|---|--------------------------|---------------------|---|--------------------------|---------------------|
| A | <input type="checkbox"/> | Under \$4,999 | F | <input type="checkbox"/> | \$30,000 - \$39,999 |
| B | <input type="checkbox"/> | \$5,000 - \$9,999 | G | <input type="checkbox"/> | \$40,000 - \$49,999 |
| C | <input type="checkbox"/> | \$10,000 - \$14,999 | H | <input type="checkbox"/> | \$50,000 - \$59,999 |
| D | <input type="checkbox"/> | \$15,000 - \$19,999 | I | <input type="checkbox"/> | \$60,000 - \$69,999 |
| E | <input type="checkbox"/> | \$20,000 - \$29,999 | J | <input type="checkbox"/> | Over \$70,000 |

PUBLIC ASSISTANCE:

- A Yes (check all that apply)
- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> TANF | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Medicaid |
- B NO PUBLIC ASSISTANCE

Mail or Fax Complete Referral To:

FACES
Attention: Intake Coordinator
3801 East Florida Avenue, Suite 715
Denver, CO 80210
Phone 720-570-9333 Fax 720-570-9339

Or Email to: cchar@facesonline.org

This form can be found on www.facesonline.org