child first

***DATE OF REQUEST FOR SERVICE:**
_____/_____/_____

Coastal Horizons
COMMUNITY BASED FAMILY SERVICES

Child First Staff Initials: _____

Transforming Lives
Trillium HEALTH RESOURCES

REQUEST FOR SERVICE

Asterisk (*) denotes fields that are always required in CFCR. Additional fields may be required based on data entry.

RFS INFORMATION

PERSON MAKING REQUEST FOR SERVICE

***Last Name:** _____ ***First Name:** _____

***Telephone:** _____

***RFS SOURCE TYPE:**

- ❑ Entry Agency – **Healthy** Mothers Healthy Babies (HMHB) **
- ❑ Entry Agency – Homesafe (HSAFE) **
- ❑ Self (Caregiver or family) *
- ❑ Birth-to-Three
- ❑ Court Personnel
- ❑ Child Welfare/Child Protective Services
- ❑ Child Developmental Services Provider
- ❑ Domestic Violence Agency or Shelter
- ❑ Early Head Start
- ❑ Early Childcare Provider/Partnership
- ❑ Emergency Mobile Psychiatric Service (EMPS)
- ❑ Faith based organization
- ❑ Family resource & support center
- ❑ Health Provider – Obstetric/adult
- ❑ Health provider – Pediatric
- ❑ Mental Health Provider – Adult
- ❑ Mental Health Provider – Child
- ❑ Pedi PCC
- ❑ Other home visiting (e.g. PAT, ICAPS)
- ❑ Public Health Service/Department
- ❑ School System
- ❑ Shelter
- ❑ Social Services
- ❑ Substance Abuse Program
- ❑ Other_____

CHILD REFERRED FOR SERVICES:

***Name:** _____

***Address:** _____

***Phone:** _____

***Child DOB:** _____/ _____ / _____
MM DD YYYY

***Gender:** ❑ Male ❑ Female

***Child Race:**

- ❑ Black or African-American
- ❑ White/Caucasian
- ❑ Asian
- ❑ American Indian/Alaskan Native
- ❑ Native Hawaiian/Pacific Islander
- ❑ Multiple /Multi-racial
- ❑ Unknown/Did not report

***Child Ethnicity:**

- ❑ Non-Hispanic, Non-Latino, Not of Spanish Origin
- ❑ Non-Hispanic – Caribbean
- ❑ Non-Hispanic – Haitian
- ❑ Hispanic – Cuban
- ❑ Hispanic – Mexican (or Mexican American, Chicano)
- ❑ Hispanic – Puerto Rican
- ❑ Hispanic – South or Central American
- ❑ Hispanic – Other
- ❑ Unknown

***Language:**

- ❑ English
- ❑ Spanish
- ❑ Portuguese
- ❑ French creole
- ❑ Other, please specify: _____

***Child insurance status:**

❑ No medical insurance coverage
❑ Medicaid / PHP
❑ Medicare
❑ Private insurance
❑ Tri-Care
❑ Unknown

ADULT TO BE INVOLVED IN SERVICES

***Is the adult to be involved in services the same person as above? (Person making RFS)** ❑ Yes ❑ no

If 'No':

***Name:** _____

***Address:** _____

_____

***Phone:** _____

***Relation to child:** ❑ Birth Father ❑ Birth Mother ❑ Foster Mother ❑ Foster Father ❑ Step Mother ❑Step Father ❑Adoptive Mother ❑Adoptive Father ❑Female Relative (e.g. grandma, aunt) ❑Male Relative (e.g. grandpa, uncle) ❑Unrelated female adult ❑Unrelated male adult ❑Mother's Live-in partner ❑Father's Live-in partner ❑Other

ADDRESS FOR HOME VISITS

Will the home visits take place at the child's physical address in CFCR?

❑ Yes ❑ No ❑ Unknown at this time

If 'No,' enter the address below.

Address for Home Visits (different from Child's physical address in CFCR)

Street 1: _____

Street 2: _____ **APT/Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Zip + 4:** _____

REASONS FOR RFS

REASONS FOR RFS: (Check all that apply)

❒ Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY)
❒ Child developmental/educational concerns
❒ Child behavioral/emotional concerns (Home)
❒ Child behavioral/emotional concerns (School or Child Care)
❒ Child exposure to domestic violence
❒ Child exposure to community violence
❒ Child abuse/neglect
❒ Need for parenting education
❒ Imminent risk of or recent out-of-home placement
❒ Risk of or recent child expulsion from child care or school
❒ Homelessness or risk of family eviction
❒ Major child/family health concerns
❒ Parent/caregiver mental health concerns
❒ Parent/caregiver substance abuse
❒ Parent/caregiver educational needs
❒ Service coordination needs
❒ RFS Source did not identify a reason
❒ None/none listed
❒ *Other (please describe)
_____

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY: (Check all that apply)

- ❑ Birth to Three
- ❑ Court personnel
- ❑ Child welfare – Investigation
- ❑ Child welfare – Alternative services
- ❑ Public support services (e.g. Social services, developmental services)
- ❑ Public health services (WIC, Healthy Start)
- ❑ 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 provider – adult
- ❑ Health provider – pediatric
- ❑ 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
- ❑ Substance abuse program
- ❑ None/none listed
- ❑ *Other (please describe)

_____

REASONS FOR RFS NARRATIVE:

*Please include events that led to the referral, other agencies involved with the family, and whether the family has previous history with Child First if applicable.

_____

_____

_____

_____

_____

_____

_____

_____

_____

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:_____

Referent signature: _____

Date:_____

PLEASE RETURN TO: Fax completed referral forms to 910-202-5772 (Attention: Child First).
Cases may be staffed with Child First Supervisors (910) 202-3155