**Internal Use Only**
**Received by:** _____
**Date received:**_____
**Date contacted referral source:**_____
**Date contacted family:**_____

Coastal Horizons Center, Inc.
Promoting Choices for Healthier Lives and Safer Communities

# Intensive Family Preservation Referring Agency Referral Form – DSS

*This form may be signed by the referring Social Worker's Supervisor and sent to the IFPS program to begin a referral. The Supervisor's signature verifies that all information below is correct and the family does in fact meet the criteria for provision of IFPS services as outlined in the State's IFPS Policies & Procedures. Although this form is sufficient to begin a referral, the IFPS worker will need actual copies of forms soon after starting work with the family.*

**Referring Agency**: _____ County DSS
Referring Worker: _____ Phone: _____
Supervisor Name: _____ Phone: _____
Supervisor Signature: _____ Date: _____

**Client Information**: Family Name: _____ Phone: _____
Address: _____
**Parent/Caretaker(s)**: attach additional sheets if there are more caregivers/children
1. Name: _____ Relationship to child: _____ Age:_____
2. Name: _____ Relationship to child: _____ Age:_____
**Child(ren):**
1. Name: _____ SIS number: 200_____
DOB: _____ Primary maltreatment type found: (field 31 on 5104) _____
2. Name: _____ SIS number: 200_____
DOB: _____ Primary maltreatment type found: (field 31 on 5104) _____
3. Name: _____ SIS number: 200_____
DOB: _____ Primary maltreatment type found: (field 31 on 5104) _____
4. Name: _____ SIS number: 200_____
DOB: _____ Primary maltreatment type found: (field 31 on 5104) _____
5. Name: _____ SIS number: 200_____
DOB: _____ Primary maltreatment type found: (field 31 on 5104) _____

**DSS Referrals:** Type found was which of the following:

δ substantiation of abuse, neglect or dependency **AND** a rating of high or intensive on the Risk Assessment

δ finding of services needed **AND** a rating of high or intensive on the Risk Assessment (family assessment cases)

δ substantiation of ***abuse*** (for abuse only, any risk rating is allowable)

DSS Risk Rating: δ Intensive δ High δ Moderate δ Low Date of Substantiation/Svcs Needed: _____

Note: *If Substantiation occurred, maltreatment information in previous section must be completed.*

Check all forms that are attached. (Note: If forms not attached, please forward to IFPS worker asap)

δ DSS 5027 δ Family Risk Assessment or Reassessment (5230 or 5226) δ NC Safety Assessment (5231)

δ Family Strengths and Needs (5229) δ Case Decision Summary/Initial Case Plan (5228)

**Internal Use Only**
**Received by: _____**
**Date received:_____**
**Date contacted referral source:_____**
**Date contacted family:_____**

**IFPS Agency:** Date/Time Received: _____ Staff Assigned: _____

Action Taken: _____

**Please fax this form to (910) 202-5772, Attention: Joshua Main, IFPS State Program Coordinator. Please label fax as URGENT OR email this form to jmain@coastalhorizons.org- Subject: Intensive Family Preservation Referral.**

**After Hours or Weekend Referrals should be faxed but accompanied with a phone call with either**

**Logan Keziah, IFPS Region 11 Supervisor 910-612-6338**

**Or**

**Joshua Main, IFPS State Program Coordinator 910-524-6630**