

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: _____
<u>Note:</u> If Substantiation occurred, maltreatment information in previous section <u>must</u> be completed.
<u>Check all forms that are attached.</u> (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)

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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

Mandi Mitchell, IFPS Region 9 Supervisor 910-524-6629

Or

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