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| **Date of Referral** |  |

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| **Parent Information** |
| Name |  |
| Address |  |
|  |
| County |  |
| Phone Number(s) |  |
|  |
| Email |  |
| Birth Date |  |
| Gender |  |
| Ethnicity |  |
| Languages Spoken |  |

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| **Services Requested (check as many as apply)****Please call 612.877.7830 for information on availability and eligibility.** |
| In Home Parent Education  |  |
| Parent Assessment  |  |
| Parent Support Outreach Program  |  |

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| **Primary Caregiver Information (if different then parent listed above)** |
| Name |  |
| Address |  |
|  |
| County |  |
| Phone Number(s) |  |
|  |
| Email |  |
| Birth Date |  |
| Gender |  |
| Ethnicity |  |
| Languages Spoken |  |

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| **Reason for Referral****Please include background information (substantiated abuse/neglect, behavioral or safety concerns, living situation), desired outcome of service and attach supporting documentation as necessary. Call 612.877.7830 with questions.** |
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| **Involvement with County and Other Systems (check as many as apply)****Please attach supporting documentation as appropriate.** |
| Criminal Justice |  |
| Family Court |  |
| Child Protection Services (CPS) |  |
| Chemical Dependency Program |  |
| Assistance Program through State |  |
| Other |  |

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| **Other Children/Family Members** |  |  |
| **Name** | **Date of Birth** | **Gender** | **Ethnicity** |
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| **Child Protection Worker** |
| Name |  |
| Agency |  |
| Address |  |
|  |
| Phone Number(s) |  |
|  |
| Email |  |

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| **Other Contact (attach Release of Information form if applicable)** |
| Name |  |
| Agency |  |
| Address |  |
|  |
| Phone Number(s) |  |
|  |
| Email |  |

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| **Other Contact (attach Release of Information form if applicable)** |
| Name |  |
| Agency |  |
| Address |  |
|  |
| Phone Number(s) |  |
|  |
| Email |  |

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| **Supporting Documentation (check if attached)** |
| Child Protection Services (CPS) Case Plan |  |
| Psychological Evaluation  |  |
| Court Hearing Report |  |
| Individualized Education Program (IEP) Statement |  |
| Parenting Assessment |  |
| Other |  |