**Referent Information:**

## Name: County: Phone: Email:

## Visiting Party Information: *(indicate with “X”)* Parent ( ) Grandparent ( )

Name: Address: Phone: Email:

Racial Identity: Hispanic or Latinx?␣ Yes ␣No Gender Identity:

## Reason for Referral?:

## Type of Service Requested: Services invoiced at a rate per 15 minute unit unless specified

Low/Transitional Level: Check in every 15 minutes by monitor - $13.40 per unit

Medium/Group Level: Shared space - 1 monitor per 2 families - $14.20 per unit

High/1:1 Level: Private room - 1 dedicated monitor - parent coaching provided - $15 per unit

Therapeutic: Therapeutic interventions provided by qualified visit monitor - $75 per hour

Virtual: Video visit using secure Zoom call - 0.75- 1 hour sessions - $45 per session

Therapeutic Training: $375.00 one time fee and on-going support for $150.00 per month

**Expected Length of Services:**

**From: (MM/DD/YY) To: (MM/DD/YY)**

## CHILDREN

| **Child 1 Name:** | | |  | | | | Date of Birth: | | |  | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Gender |  | | | | | | Race: |  | | | |
| **Resides With: (Name/Relationship with Child)** | | | | | |  | Address: | |  | | |
| Phone number: | | | | |  | | | | | | |
| Transportation Provider: | | | | |  | | Transportation Provider Phone: | | | |  |
| Allergies: | |  | | | | | | | | | |
| **Child 2 Name**: | | |  | | | | Date of Birth: | | |  | |
| Gender |  | | | | | | Race: |  | | | |
| **Resides With: (Name/Relationship with Child)** | | | | | |  | Address: | |  | | |
| Phone number: | | | |  | | | | | | | |
| Transportation Provider: | | | | |  | | Transportation Provider Phone: | | | |  |
| Allergies: | |  | | | | | | | | | |
| **Child 3 Name:** | | |  | | | | Date of Birth: | | |  | |
| Gender |  | | | | | | Race: |  | | | |
| **Resides With: (Name/Relationship with Child)** | | | | | |  | Address: | |  | | |
| Phone number: | | | | |  | | | | | | |
| Transportation Provider: | | | | |  | | Transportation Provider Phone: | | | |  |
| Allergies: | |  | | | | | | | | | |
| **Child 4 Name:** | | |  | | | | Date of Birth: | | |  | |
| Gender |  | | | | | | Race: |  | | | |
| **Resides With: (Name/Relationship with Child)** | | | | | |  | Address: | |  | | |
| Phone number: | | | | |  | | | | | | |
| Transportation Provider: | | | | |  | | Transportation Provider Phone: | | | |  |
| Allergies: | |  | | | | | | | | | |

## List specific concerns you have regarding this family’s visit time. What should the visit monitor pay specific attention to or redirect?

1.

2.

3.

**Are there safety concerns, if so, what are they?**

☐Yes ☐No

1.

2.

3.

## Has this family been discharged from another provider?

☐Yes ☐No

If so, what were the challenges or concerns:

## General Expectations of Families

1. The visiting parent’s mandatory check-in time for each visit is 15 minutes prior to the scheduled service (example: a 5:00 visit means the visiting parent(s) must arrive by 4:45 or risk cancellation of visit).
2. No cell phones or electronics are to be used during the visit. If phones are brought to the visit they must be left in a designated location, not to be accessed during the visit. Pictures and Videos may not be taken at any time.
3. Inappropriate discipline for the age of the child will result in redirection and suspension pending a meeting
4. Parent/child boundaries will be maintained. Conversations that do not hold boundaries will be redirected.

**Guardian Ad Litem:** ☐Yes ☐No

**Contact information:** Name: Phone: Fax:

**Billing Information: (Who are invoices sent to?)**

**Name:**

**Address:**

**Phone Number:**

**Service Authorization Number:**

**SSIS #**

**This completed referral can be sent to** [**intake@familywiseservices.org**](mailto:intake@familywiseservices.org) **with the subject line “Child Welfare Referral - [Client Last Name]”. For questions or concerns please call 612-877-7838 for more information.**