REQUEST FOR SERVICE

Date: ____/_____/_____

CHILD INFORMATION:

Name (First / Last):_____ **DOB:** _____/_____/_____ **Age:** _____

Gender: ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ Other _____

Racial Origin: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African-American
(check one) ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other

Hispanic Origin: ❑ Hispanic ❑ Non-Hispanic

Client Insurance ❑ Husky A ❑ Husky B ❑ Private _____ ❑ Unknown ❑ None

CAREGIVER INFORMATION – Person(s) with whom child resides:

1st Caregiver Name: _____ **Age:** _____ **Gender**: ❑ M ❑ F ❑ T ❑ NB

Relation to child: ❑ biological parent ❑ adoptive parent ❑ foster parent ❑ relative _____ ❑ other _____

2nd Caregiver Name (optional): _____ **Age:** _____ **Gender**: ❑ M ❑ F ❑ T ❑ NB

Relation to child: ❑ biological parent ❑ adoptive parent ❑ foster parent ❑ relative _____ ❑ other _____

Street address: _____ **Town/State/Zip:** _____

Phone: (check preferred #) Home ❑: _____ Mobile ❑:_____ Work ❑: _____

Best times to contact: ❑ 7-9am ❑ 9-12pm ❑ 12-5pm ❑ 6-9pm **Email address:** _____

Is this the child's legal guardian? ❑ Y ❑ N ❑ unknown **If no, name of legal guardian:** _____

Legal guardian contact information: _____

Days & Hours available for services: ❑ M ❑T ❑W ❑Th ❑F // ❑ 8 am – noon ❑ noon – 4 pm ❑ 4-7 pm

Is English spoken fluently by caregiver/guardian? ❑ yes ❑ no ❑ unknown **Primary language:** _____

Do you have caregiver's permission to make referral? ❑ yes ❑ no **If yes,** ❑ written ❑ verbal ❑ both

Has family previously been served by Child First? ❑ yes ❑ no ❑ unknown **If yes, when?** _____

Does child/family have history of DCF involvement? ❑ none ❑ yes, present ❑ yes, past ❑ unknown
If yes: ❑ CPS ❑ FAR ❑ unknown Name of FAR agency:_____

REFERRAL SOURCE INFORMATION

Name: _____ **Relation to caregiver/guardian:** _____

Name of agency:_____ **Position:** _____

Street address: _____**Town/State/Zip**: _____

Telephone: Office: _____ **Mobile:**_____ **Fax:** _____

Best times to contact: ❑ 7-9am ❑ 9-12pm ❑ 12-5pm ❑ 6-9pm **Email address:** _____

Type of Referral Source: ❑ Caregiver self-referral ❑ Relative

❑ Birth to Three ❑ Early Childhood Consultation Partnership ❑ Home visiting (Nurturing Family, PAT,
❑ Court personnel (ECCP) EHS, NFP)
❑ Dept of Children and Families (DCF) ❑ Early childhood education/childcare ❑ Hospital – Emergency Room (ER)
❑ DCF – Home-based service (IFP, FBR, ❑ Emergency Mobile Psychiatric Service ❑ Hospital – Obstetrics
IICAPS, FES-Triple P, Caregiver Support (EMPS) ❑ Mental health provider - adult
Team, other _____) ❑ Faith based organization ❑ Mental health provider - child
❑ DCF – Care Coordination ❑ Family resource & support center ❑ Regional Education Service Center (RESC)
❑ Dept of Developmental Services (DDS) ❑ Health Department (WIC, Healthy Start) ❑ School System
❑ Dept of Social Services (DSS) ❑ Health provider – adult ❑ Shelter - family
❑ Dept Mental Health & Addiction Serv (DMHAS) ❑ Health provider – pediatric ❑ Substance abuse program
❑ Domestic violence agency or shelter ❑ Help Me Grow ❑ Other_____

Reasons for Referral: (Check all that apply)

❒ Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY) ❒ Child abuse/neglect ❒ Parent/caregiver mental health
❒ Risk of child out-of-home placement ❒ Parent/caregiver substance abuse
❒ Child developmental/educational concerns ❒ Risk of child expulsion from school ❒ Parent support and education needs
❒ Child behavioral/emotional concerns ❒ Risk of family eviction ❒ Service coordination needs
❒ Child exposure to violence ❒ Major child/family health concerns ❒ Other (please specify):_____

Other Services/Agencies Currently Involved with Child/Family: (Check and circle program if appropriate)

❑ Birth to Three ❑ Early Childhood Consultation Partnership ❑ Home visiting (Nurturing Family, PAT, EHS, NFP)
❑ Court personnel (ECCP)
❑ Dept of Children and Families (DCF) ❑ Early childhood education/childcare ❑ Hospital – Emergency Room (ER)
❑ DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other _____) ❑ Faith based organization ❑ Emergency Mobile Psychiatric Service (EMPS) ❑ Hospital – Obstetrics ❑ Mental health provider - adult ❑ Mental health provider - child
❑ DCF – Care Coordination ❑ Family resource & support center ❑ Regional Education Service Center (RESC)
❑ Dept of Developmental Services (DDS) ❑ Health Department (WIC, Healthy Start) ❑ Shelter – family
❑ Dept of Social Services (DSS) ❑ Health provider – adult ❑ School System – Special Education
❑ Dept Mental Health & Addiction Serv (DMHAS) ❑ Health provider – pediatric ❑ Substance abuse program
❑ Domestic violence agency or shelter ❑ Help Me Grow ❑ Other_____

REFERRAL INFORMATION

Please describe the concerns that have led to this referral: *Please also indicate if referral is urgent and why.*
If DCF referral, please indicate status and goals _____

_____

_____

_____

_____

I _____ , legal guardian of _____ , give permission for this referral to be sent to the Child First affiliate agency, The Child Guidance Center of Southern Connecticut, 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:_____

Referrant signature: _____ Dare:_____

PLEASE ATTACH THE CHILD FIRST CONSENT FOR SERVICES OR YOUR AGENCY'S SIGNED RELEASE OF INFORMATION FORM

PLEASE RETURN TO: Child First Director, Erica Pomerantz, Psy.D
pomerae@chc1.com