



FAMILIES FIRST PROGRAM
Intensive In-Home Family Service
Referral Form

Official Use Only
Assigned Specialist: _____ Family Number: _____
Date Case Assigned: _____ Start Date: _____

Person Making Referral: _____ Date: _____
Agency: _____ Phone: _____
Address to Send Reports: _____
email address: _____
How did you hear about Families First? _____

Referred Child/Youth: _____ Juvenile Court Number: _____
Address: _____ City: _____
Zip Code: _____ Home Phone: _____ Date of Birth: _____
Age: _____ Sex: [] M [] F Court Status: _____ Language Preference: _____
School: _____ Other Programs Youth Involved in: _____

(Please check [] if person is living at home of the youth)

[] Mother's Name: _____
Mother's Work Phone: _____ Mother's Cell Phone: _____
[] Father's Name: _____
Father's Work Phone: _____ Father's Cell Phone: _____
[] Step Parent/Guardian: _____
Step Parent/Guardian Work/Cell Phone(s): _____

List all children in home by age:

Name: _____ Age: _____ Date of Birth: _____
Name: _____ Age: _____ Date of Birth: _____
Name: _____ Age: _____ Date of Birth: _____
Name: _____ Age: _____ Date of Birth: _____
Name: _____ Age: _____ Date of Birth: _____

Other people in the home:

Name: _____ Relationship: _____ Date of Birth: _____
Name: _____ Relationship: _____ Date of Birth: _____

The parents understand that the Families First service is a minimum of six weeks and eight hours per week in the family's home. [] Yes [] No

Family Schedule:

Work: [] Mon. _____ [] Tues. _____ [] Wed. _____ [] Thur _____
[] Friday. _____ [] Sat. _____ [] Sun. _____

Vacation: _____

History of Referred Child/ Youth:

Prior Out Patient? Yes No How Long? _____ With Whom? _____

Is the above Person Recommending Residential Treatment? Yes No

Prior Acute Care? Yes No When? _____ Where? _____

Reason for Acute Care: _____

Where is the child at the time of this referral? _____

If the child is not in the home, can he/she be returned home within 7 days? Yes No

Please explain: _____

Problem Checklist: (Please check [✓] any of the following problems that you think the family/ child is experiencing. Also, please identify persons involved and provide a description regarding the degree of the problem in the space below.)

Continuing Problems- Family

Contributing Problems- Referred Child/Youth)

- AB Abuse/exploitation by non-family member
- DA Parent drug/alcohol problem
- EA Emotional abuse by a parent
- FV Family violence
- IL Parent handicap/illness
- IR Inadequate physical resources

- NG Neglect
- PA Physical abuse by parent
- PC Parent-Child conflict
- RS Parent too restrictive/ protective
- SA Sexual abuse by parent
- UE Parent unemployment

- AA Alcohol abuse
- BP Behavior problems/ delinquent
- CC Custody change
- DP Depressed
- DR Drug abuse
- HH Health problem/handicap
- LD Learning disability

- MI Mental/emotional illness
- MR MR/DD
- PG Pregnancy/unwed
- RW Runaway
- SP Suicide potential
- SX Sexual acting out
- TR Truancy

Please Explain: _____

What do you expect the Families First Specialist to accomplish? _____

**Please Fax to: Utah Youth Village
c/o Sheila Gledhill
(866) 546-3865 (Sheila)
(801) 272-9976 (Village)**

**Mailing Address: Utah Youth Village
5800 Highland Dr.
Salt Lake City, Utah 84121
(801) 272-9980**