FAMILIES FIRST PROGRAM
Intensive In-Home Family Services
Referral Form

Official Use Only
*Assigned Worker:*_____ *Family Number:* _____
*Date Case Assigned:*_____ *Start Date:* _____

Referring Worker:_____ Date:_____
Agency:_____ Phone: _____
Secure Email to Send Reports:_____
Address to Send Reports *(optional if being emailed):*_____
Court Status:_____ Language Preference: _____ School:_____
How did you hear about Families First?_____

Referred Child/Youth:_____ Legal Number (if assigned):_____
Address:_____ City:_____
Zip Code:_____ Phone:_____ Date of Birth:_____

(*Please check [T] if person is living at home.*)
□ Mother:_____ Date of Birth:_____
□ Father:_____ Date of Birth:_____
□ Step Parent/Guardian:_____ Date of Birth:_____
Parent/Guardian Work Phone(s):

Diagnosis: Axis I_____ Code_____
Axis II_____
Axis III_____
Axis IV_____
Axis V_____

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

Other people in home:
Name:_____ Relationship:_____ Date of Birth:_____
Name:_____ Relationship:_____ Date of Birth:_____

Referring worker explained the Families First services to the parent/guardian previous to submitting this referral? □Yes □No

Family Schedule:

Work: □Mon._____ □Tues. _____ □Wed. _____ □Thur. _____
□Fri. _____ □Sat._____ □Sun._____

Vacation:_____

History of Referred Child/Youth:

Prior Out Patient? □Yes □No How Long?_____ With Whom?_____
Psychiatrist:_____ Psychologist:_____ Social Worker:_____
School:_____
Is the above Person Recommending Residential Treatment? □Yes □No
Prior Acute Care? □Yes □No When?_____ With Whom?_____ 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 [T] 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

□ 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

Continuing Problems – Target Child(ren)

□ 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?_____
_____
_____
_____
_____
_____
_____
_____
_____

PRIMARY INSURANCE (if applicable)

Policy Holder:_____ SS#:_____ DOB:_____
Relationship to Insured:_____
Employer:_____ Group #:_____
Insurance Company:_____ Phone #:_____
Effective Date:_____ Exclusions/Restrictions:_____
Benefits:____% OOP:____ Ded:____ CYM:____ Verified By:_____
Notes:_____

SECONDARY INSURANCE (if applicable)

Policy Holder:_____ SS#:_____ DOB:_____
Relationship to Insured:_____
Employer:_____ Group #:_____
Insurance Company:_____ Phone #:_____
Effective Date:_____ Exclusions/Restrictions:_____
Benefits:____% OOP:____ Ded:____ CYM:____ Verified By:_____
Notes:_____

NOTES/FOLLOW-UP

Please Fax to:	**Utah Youth Village** **c/o Wayne Arner** **(866) 546-3865 (FF Dep.)** **(801) 272-9976**	**Mailing Address:**	**Utah Youth Village** **5800 Highland Dr.** **Salt Lake City, Utah 84121** **(801) 272-9980**
Web Site:	**www.youthvillage.org**		