Family Resource CONNECTION

Central Fax: 866-528-0579

PROGRAM REFERRAL

Date: _____

CASE NAME: _____

CASE WORKER: _____

COUNTY: _____

Group Services

- ☐ Coping & Healing After Divorce - Children
- ☐ Parenting
- ☐ Children of Substance Abuse
- ☐ Anger Management - Adult
- ☐ Anger Management - Adolescent
- ☐ Choices & Changes (BIP)

Individual / Family Services

- ☐ Monitored Exchanges
- ☐ Individual Parenting
- ☐ Co-Parenting (with both parents)
- ☐ Individual Anger Management
- ☐ In-home Parenting
- ☐ Alcohol/Drug Testing
- ☐ Supervised Visitation
  - ☐ Tier I (100%)
  - ☐ Tier II (80%)
  - ☐ Tier III (50%)
  - ☐ Supportive Visitation

Parents

Parent Name 1: _____ *DOB:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Parent Name 2: _____ *DOB:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Parent Name 3: _____ *DOB:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Referral Information

Case No# / Div / Judge: _____ / _____ / _____

Visitation Requirements: _____ *Frequency:* _____

Benchmark Visitation Guidelines

Child's Age	Frequency
Birth-6 Months	3X/wk for 30-60 minutes
6 Months- 18 Months	3X/wk for 30-60 minutes
18 Months- 3 Years	2X/wk for 1.5 hours
3 Years – 5 Years	2X/wk for 2 hours
5 Years – 12 Years	1X/wk for 2 hours
12 Years – 18 Years	No Recommendation

Does visitation requirements and frequency meet Benchmark Guidelines? *Yes* _____ *No* _____

Race: *American Indian(AI), Alaska Native(AN), Asian(AS), Black(BK), African American(AA), Native Hawaiian(HI), Other Pacific Islander(PI), White(WH)*
Ethnicity: *Hispanic or Latino(HL), Not Hispanic or Latino(NL)*

Child 1 Information

GAL Contact: _____

Name: _____

DOB: _____ *Race:* _____ *Ethnicity:* _____

Gender (check one): Male _____ *Female* _____

Caregiver Name: _____ Phone: _____

Others Allowed to Visit: _____

Child 2 Information

GAL Contact: _____

Name: _____

DOB: _____ *Race:* _____ *Ethnicity:* _____

Gender (check one): Male _____ *Female* _____

Caregiver Name: _____ Phone: _____

Others Allowed to Visit: _____

Child 3 Information *GAL Contact:* _____

Name: _____

DOB: _____ *Race:* _____ *Ethnicity:* _____

Gender (check one): Male _____ *Female* _____

Caregiver Name: _____ Phone: _____

Others Allowed to Visit: _____

Child 4 Information *GAL Contact:* _____

Name: _____

DOB: _____ *Race:* _____ *Ethnicity:* _____

Gender (check one): Male _____ *Female* _____

Caregiver Name: _____ Phone: _____

Others Allowed to Visit: _____

Family Income & General Information

☐ *Less than $10,000*
☐ *10,001 - 20,000*
☐ *20,001 - 29,999*
☐ *30,000 - 39,999*
☐ *40,000 and above*

Financials on file? *Yes* ☐ *No* ☐

Attorney for Parent 1: _____

Phone Number: _____ *e-mail:* _____

Attorney for Parent 2: _____

Phone Number: _____ *e-mail:* _____

Attorney for Parent 3: _____

Phone Number: _____ *e-mail:* _____

Reason for Referral

Child abuse alleged ☐ *Sexual abuse alleged* ☐ *Domestic Violence alleged* ☐

Other? _____

_____

Transportation type: _____

Mental health Issues: _____

Security concerns: _____

Therapist name/phone: _____

School problems: _____

Child orientation completed: _____

Intake Questions (office use only)

Do you have health insurance for your child? *Yes* ☐ *No* ☐

Are you aware of the low-cost healthcare insurance available through the Florida Healthy Kids program? *Yes* ☐ *No* ☐

(FRC representative review information on FHKC program if child has no health insurance)

FHKC application completed? *Yes* ☐ *No* ☐ *If no, give reason why:* _____

_____