FAMILY BRIDGES PROGRAM
PRESERVATION REFERRAL/INTAKE

(For Family Bridges Office Use)

FAMILY BRIDGES CASE# _____ DHR CASE #: _____

DATE/TIME RECEIVED BY FAMILY BRIDGES:_____/_____:_____am/pm

DATE/TIME ASSIGNED TO SPECIALIST:_____/_____:_____am/pm

Specialist: _____ Referral Completed By: _____

Referring Worker:_____ County:_____ Phone:_____

Referral Supervisor: _____Phone: _____

Check One: ___Protective Services ___Foster Care ___Adoptions ___Other:_____

Will you be able to accompany Family Bridges on their first home visit? YES _____ NO_____

OR

Do you want Family Bridges to call you after the first face-to-face visit? YES _____ NO_____

Last DHR contact with the family:_____

Parent/Legal Guardian:

_____ ___/___/___ _____ _____/_____

Name DOB Age Race/Sex

_____-_____-_____ _____

Social Security Number Relationship to Child

_____ ___/___/___ _____ _____/_____

Name DOB Age Race/Sex

_____-_____-_____ _____

Social Security Number Relationship to Child

Who has custody of the PR(s)?_____

Address:_____ Best time to Contact Family:_____

_____ _____

ZIP CODE:_____ Directions to House:

Home Phone:_____ _____

Work Phone:_____ _____

Other Contact Name: _____ _____

_____ _____

Relationship: _____ _____

Phone: _____ _____

FAMILY:

Children in Imminent Danger of Placement **(P.R.'s)** and their Living Situation (Home, Shelter, Relative, etc.) at Time of Referral:

1. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

2. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

3. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

4. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

5. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

6. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

Number of Other Children Living in the Home:_____

1. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

2. _____ ___/___/___ ____ ____ ____
Name DOB Age Sex Race

Social Security Number:_____ Living Situation: _____

Other Adults Living in the Home, Date of Birth, and Relationship:

_____

_____

_____

_____

INCOME SOURCE: TANF_____ SSI_____ EMPLOYMENT_____ OTHER_____

Characteristics of Child/Family at Risk:

[ ] Child Abuse
[ ] Child Behavior
[ ] Criminal/Police Records
[ ] Developmental Disability
[ ] Domestic Violence
[ ] Emotional Abuse
[ ] Family Conflict
[ ] General Neglect
[ ] Hard Services Needs
[ ] Home Management
[ ] Medical Illness/Disability
[ ] Medical Neglect
[ ] Mental Health
[ ] Parent/Child Conflict
[ ] Parenting Issues
[ ] Past Suicide Attempts
[ ] Physical Violence
[ ] Prostitution
[ ] Runaway
[ ] Severe Financial Hardship
[ ] Sexual Abuse
[ ] Substance Abuse
[ ] Suicidal
[ ] Teen Pregnancy
[ ] Truancy/School Problems
[ ] Other_____

Is the Child or Children at Imminent Risk of Placement? _____YES _____NO

A. Who would Initiate Placement? DHR PARENT(S) OTHER (Specify)

B. In the Event of Removal, Child(ren) at Risk will be placed as Follows:

Relative Placement _____ Foster Care _____

Therapeutic Foster Care _____ Basic Care _____

Moderate Care _____ Intensive Care _____

Mothers & Infants _____ TLP/ILP _____ Other _____

PRECIPITATING CRISIS:_____

_____

_____

_____

_____

_____

REFERRING WORKERS EXPECTATIONS OF FAMILY BRIDGES SERVICES: (What circumstances **must change** for child to remain in the home?)

_____

_____

_____

_____

_____

_____

Has there been an ISP?_____ Date of last ISP_____(Please send copy)

If no, is one scheduled? _____ Date Scheduled _____

PLACEMENT HISTORY (Dates and Locations if known):

DHR _____

_____

OTHER AGENCY _____

_____

INFORMAL _____

_____

PREVIOUS/CURRENT COUNSELING OR SERVICES PROVIDED (Programs, Participants, Dates, Diagnosis, Medications, Results):

_____

_____

_____

OTHER SUPPORT SYSTEMS INVOLVED: _____

_____

_____

COURT HEARINGS PENDING:

(Specify dates, prior delinquent behavior, special circumstances)

_____ NONE

_____ CHINS

_____ PERIODIC REVIEW/DISPOSITIONAL

_____ DELINQUENT CHARGES-CHILD

_____ DEPENDENCY

_____ UNKNOWN

_____ CRIMINAL CHARGES-PARENTS

_____ SHELTER CARE/72HR. HEARING

SAFETY ISSUES

DHR ASSESSMENT OF THE POTENTIAL FOR PHYSICAL VIOLENCE:

WITHIN THE FAMILY:

1-EXTREME 2-HIGH 3-MODERATE 4-LOW 5-NONE

COMMENTS: _____

_____

TOWARD OTHERS ENTERING THE HOME:

1-EXTREME 2-HIGH 3-MODERATE 4-LOW 5-NONE

COMMENTS: _____

_____

WITHIN THE COMMUNITY:

1-EXTREME 2-HIGH 3-MODERATE 4-LOW 5-NONE

COMMENTS: _____

_____

Any Past or Present Abuse/Neglect in the Home? _____YES _____NO

If YES, please explain: _____

_____

_____

_____

_____

Referring Worker's safety plan: _____

_____

_____

_____

CHILD SAFETY RATINGS

(*R*eferring worker will rate this issue at the beginning of Services and at Service Closure based upon the following rating scale:

N/A	Situation has changed; no longer an issue.
(-)	Situation has worsened.
1.	The current situation is not tolerable. It's not working. Things are very bad. The situation is desperate. A great amount of help is needed.
2.	The current situation is not tolerable more than half the time. Some help is needed.
3.	The current situation is OK more than half the time. Little help is needed.
4.	The current situation is very good. Things are under control. No help is needed at this time.
5.	Expectations have been exceeded.
6.	Unable to obtain (This applies to **Service Closure Rating** only.)

RATINGS

Referring Worker's Rating at the **Beginning** of Services: _____

Referring Worker's Rating at **Service Closure:** _____

Initials/Signature of Supervisor (or another specialist) who reviewed for appropriateness of referral:

_____ **Date:** _____