FAMILY BRIDGES PROGRAM
REUNIFICATION 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:_____

Reason reunification services are requested (include source and date of previous services used and results):

_____

_____

_____

Has the Family Planning Team (those involved in the ISP) agreed that the goal is reunification? _____

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 _____

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

Address: _____ Best time to Contact/Comments: _____

_____ _____

Home Phone #: _____ Work Phone #: _____

Alt. Phone #: _____ Contact Name: _____

Directions to House: _____

_____

With whom (or where) do the children presently reside?: _____

_____

Current Visitation Plan: _____

_____

_____

_____

Address: _____ Best time to Contact/Comments: _____

_____ _____

Home Phone #: _____ Work Phone #: _____

Alt. Phone #: _____ Contact Name: _____

Directions to Residence: _____

_____

_____

Child or Children (List children to be reunited first):

1. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

2. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

3. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

4. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

5. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

6. _____ ___/___/___ _____ _____ _____ _____
Name DOB Social Security Number Age Sex Race

Living Situation:
Relative Placement _____ Foster Care _____ Therapeutic Foster Care _____ Basic Care _____
Moderate Care _____ Intensive Care _____ Mothers & Infants _____ TLP/ILP _____ Other _____

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

_____

_____

_____

Family Income Source: TANF_____ SSI_____ EMPLOYMENT_____ OTHER_____

Issues Which Indicated Removal of Child(ren):

[ ] 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_____

Progress made regarding these issues since removal: _____

_____

_____

_____

_____

Referring worker's expectations of Family Bridges Reunification Services: (What circumstances must change for Family Reunification to take place?) _____

_____

_____

_____

_____

Referring worker's safety plan: _____

_____

_____

_____

Date of last ISP _____(please send copy) Date of last court hearing _____

Date next ISP scheduled _____ Date of next scheduled court hearing _____

Family Strengths: _____

_____

_____

Placement History (dates and locations): _____

DHR: _____

_____

Other Agency: _____

_____

_____

Informal: _____

_____

_____

Previous/Current Counseling or Services Provided: (programs, participants, dates, diagnoses, medications, results):

_____

_____

_____

_____

Other Support Systems Involved: _____

_____

_____

Court of Jurisdiction: _____

_____

_____

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: _____

_____

Please provide a ***Child Safety*** rating based on the following scale:

(-)	**Situation has worsened.**
1	**The current situation is not tolerable. A great amount of help is needed before reunification can be achieved.**
2	**The current situation is not tolerable more than half the time. Some help is needed before reunification can be achieved.**
3	**The current situation is OK more than half the time. Reunification will take place soon.**
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: _____**

Other Pertinent Information: _____

_____

_____

_____

_____

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

_____ Date: _____