

Intensive Family Preservation Referring Agency Referral Form – MH

Clinicians may complete this form and send to an IFPS program to begin a referral. The Supervisor's signature verifies that all information below is correct and the family does meet the criteria for provision of IFPS services as outlined in the State's IFPS Policies & Procedures.

Referring Agency: _____

Referring Worker: _____

Phone: _____

Referring Worker's email address: _____

Supervisor Name: _____

Phone: _____

Supervisor Signature: _____

Date: _____

Client Information: Family Name: _____ Phone: _____

Address: _____

Parent/Caretaker(s): attach additional sheets if there are more caregivers/children

1. Name: _____ Relationship to child: _____ Age: _____

2. Name: _____ Relationship to child: _____ Age: _____

Child(ren):

1. Name: _____ SIS number/NCFAST _____

DOB: _____

2. Name: _____ SIS number/NCFAST _____

DOB: _____

3. Name: _____ SIS number/NCFAST _____

DOB: _____

4. Name: _____ SIS number/NCFAST _____

DOB: _____

5. Name: _____ SIS number/NCFAST _____

DOB: _____

Mental Health referral must include both of the following:

Without Intensive Services, youth will be referred to a residential or inpatient setting

and

A standardized assessment tool demonstrates the child is at imminent risk of removal from the home

IFPS Agency: Date/Time Received: _____ Staff Assigned: _____

Action Taken: _____