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: _________________________________ Check box if child meets criteria for services
   DOB: _______________
2. Name: _________________________________ Check box if child meets criteria for services
   DOB: _______________
3. Name: _________________________________
   DOB: _______________
4. Name: _________________________________
   DOB: _______________
5. Name: _________________________________
   DOB: _______________

Mental Health referral must include both of the following:

The child's treatment team has determined that 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: ____