DHR Promoting Safe and Stable Families FFY 2016

Children's Advocacy Center of Lowndes County, Inc.

Referral Form

Children's Advocacy Center OF LOWNDES COUNTY, INC.

Phone 229-245-5362
Fax 229-245-5360

Referring Agency

Caseworker/Detective (your name)	**Date:**	
Referring Agency (agency name and county)	**Telephone:**	**Fax:**

Referral Source

Check one.

- ☐ DFCS – CPS Investigating
- ☐ DFCS – CPS Fam. Preservation
- ☐ DFCS – CPS Family Support
- ☐ DFCS – Placement Services
- ☐ Hospital
- ☐ MH/MR/SA
- ☐ Juvenile/Family Court
- ☐ Law Enforcement
- ☐ Other community agency
- ☐ Previous or current participant
- ☐ Probation
- ☐ Self
- ☐ Shelter
- ☐ School
- ☐ Health Department
- ☐ Other. Specify:

Referral Information *Please ensure that all information is provided in the sections below before faxing.

Agency/Program family is being referred to: **Children's Advocacy Center (CAC) of Lowndes County, Inc.**

Reason for referral.

- ☐ Academic support
- ☐ After school activities
- ☐ Child physical abuse
- ☐ Child behavior
- ☐ Child neglect
- ☐ Counseling
- ☐ Crisis intervention
- ☐ Domestic violence
- ☐ Health management
- ☐ Life skills training
- ☐ Parenting
- ☐ Placement support
- ☐ Relative caregiver support
- ☐ Reunification plan
- ☐ Other. Specify:
- ☐ School absenteeism
- ☐ Sexual abuse
- ☐ Substance abuse
- ☐ Teen pregnancy

Please **circle** service(s) you're requesting

1. Service Requested, please circle: **Forensic Interview** (can only be *requested by law enforcement/DFCS* /DA) **or Counseling**

2. Below provide a **brief summary** of abuse or allegation. **Identify the alleged perpetrator by name** and how he/she is known to the child. **If a forensic is needed, please fax a completed referral form to the CAC before calling to schedule an interview.**

DFCS Family Status

- ☐ No Known CPS/DFCS Involvement
- ☐ CPS Screen Out
- ☐ CPS Family Support(DR)
- ☐ Child(ren) in Foster Care
- ☐ CPS Investigating
- ☐ CPS Ongoing/Family Preservation
- ☐ Closed/Closing CPS
- ☐ Closed Placement

Law Enforcement Agency

Detective /Investigator if an interview is requested

Family Information: *Please ensure that all information is provided in the sections below before faxing.

Parent/Primary Caregiver:

Relationship to child:

SS #:_____ D.O.B:_____ Race:_____

Home Phone:_____ Cell:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

County of Residence:_____

List **Name and Date of Birth** of **all** individuals of whom services are requested:

Child's Name: _____ D.O.B:_____ Sex:___ Race:_____

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Child's Name: _____ D.O.B:_____ Sex:___ Race:_____

Status of Referral. To be completed by service provider.

- ☐ Attempts to contact family have been unsuccessful.
- ☐ Family contacted but declines services.
- ☐ Services can begin immediately. **Program:** _____
- ☐ Waitlisted for future services. Expected start date:

Date referring agency notified of status:

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