



## SFFC Referral Form

Contact Details			
Date of Submission/Contact:		Time:	
Type of Contact:	<input type="checkbox"/> Call <input type="checkbox"/> Web <input type="checkbox"/> Email <input type="checkbox"/> In Person		
Staff:			
Contact with Client (Date):		Voicemail (Date):	
Other Contact:			

Caller			
Type:	<input type="checkbox"/> New Caller <input type="checkbox"/> Returning Caller <input type="checkbox"/> Referral Source		
Name of Caller:		Phone Number:	
Organization Name:		Family Connection to Organization:	
Does Family Know about the Call?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do we have Permission to Call the Family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Caller is Client – Do you give us permission to speak to the referring source about his situation?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Person:		Phone Number:	

Referral Source	
How did you hear about us?	<input type="checkbox"/> Church <input type="checkbox"/> Returning Caller <input type="checkbox"/> Friend <input type="checkbox"/> Community Organization <input type="checkbox"/> Internet <input type="checkbox"/> Presentation <input type="checkbox"/> Other:
Name of Referring Source:	

Family Information				
Name:		Email:		
Phone Number:		Alternative Number:		
Address:		City:		
County:		State:		Zip

Child(ren)'s Names	Age	Gender	Special Needs/Behaviors	School/Daycare?

List other family members:	
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List Existing Resources:	
Other Notes:	

**Identified Concerns (check all that apply)**

Child behavior/medication problem   
 Child Welfare Investigation   
 Domestic Violence   
 Family Conflict  
 Homelessness   
 Medical Hospitalization   
 Psychiatric Hospitalization   
 Human Trafficking  
 Medical Crisis   
 Mental Health Crisis/Treatment Needed   
 Respite   
 Safety Plan   
 Substance Abuse  
 Unemployment   
 Incarceration   
 Lack of Family Support   
 Refugee  
 Other Potential Crisis/Instability:

**Of identified concerns, which is primary:** \_\_\_\_\_ **which is secondary:** \_\_\_\_\_

**Goals**

Primary goal that family wants to achieve with help of SFFC:	
Secondary goal that family wants to achieve with help of SFFC:	
Estimated length of hosting:	
Referral(s) Given:	<input type="checkbox"/> DSS <input type="checkbox"/> Adoption Agency <input type="checkbox"/> Material Assistance <input type="checkbox"/> Financial Support <input type="checkbox"/> Other:

**Outcome**

Assignment Made (HH/FF)   
 Considered/Volunteer Not Available   
 Considered/Bio Family Withdrawal  
 Not Eligible   
 no Call Back

**Status**

Entered in Google Doc Initials: \_\_\_\_\_ Date: \_\_\_\_\_   
 Pending   
 Closed Case

NOTES:	
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