



*DATE OF REQUEST FOR SERVICE:

REQUEST FOR SERVICE

Child First Staff Initials: _____

By this point, the index child's basic information should already be entered into CFCR including, but not limited to, name, gender, DOB, address, race, ethnicity and language. If any information is missing, please go back to Child Demographics and/or Child Address & Phone Number(s) to update once information is obtained.

Asterisk () denotes fields that are always required in CFCR. Additional fields may be required based on data entry.

RFS INFORMATION

PERSON MAKING REQUEST FOR SERVICE

*Last Name: _____ *First Name: _____

*Telephone: _____

*RFS SOURCE TYPE:

- Entry Agency - Healthy Mothers Healthy Babies (HMHB) **
Entry Agency - Homesafe (HSAFE) **
Self (Caregiver or family) *
Birth-to-Three
Court Personnel
Child Welfare/Child Protective Services
Child Developmental Services Provider
Domestic Violence Agency or Shelter
Early Head Start
Early Childcare Provider/Partnership
Emergency Mobile Psychiatric Service (EMPS)
Faith based organization
Family resource & support center
Health Provider - Obstetric/adult
Health provider - Pediatric
Mental Health Provider - Adult
Mental Health Provider - Child
Pedi PCC
Other home visiting (e.g. PAT, ICAPS)
Public Health Service/Department
School System
Shelter
Social Services
Substance Abuse Program
Other

CHILD REFERRED FOR SERVICES:

*Name: _____

*Address: _____

*Phone: _____

*Child DOB: MM/DD/YYYY

*Gender: Male Female

*Child Race:

- Black or African-American
White/Caucasian
Asian
American Indian/Alaskan Native
Native Hawaiian/Pacific Islander
Multiple /Multi-racial
Unknown/Did not report

*Child Ethnicity:

- Non-Hispanic, Non-Latino, Not of Spanish Origin
Non-Hispanic - Caribbean
Non-Hispanic - Haitian
Hispanic - Cuban
Hispanic - Mexican (or Mexican American, Chicano)
Hispanic - Puerto Rican
Hispanic - South or Central American
Hispanic - Other
Unknown

*Language:

- English
Spanish
Portuguese
French creole
Other, please specify: _____

***Child insurance status:**

- No medical insurance coverage
- Medicaid
- Medicare
- Private insurance
- Tri-Care
- Unknown

ADULT TO BE INVOLVED IN SERVICES

***Is the adult to be involved in services the same person as above? (Person making RFS)** Yes no

If 'No':

***Name:** _____

***Address:** _____

***Phone:** _____

- *Relation to child:** Birth Father Birth Mother Foster Mother Foster Father Step Mother Step Father
 Adoptive Mother Adoptive Father Female Relative (e.g. grandma, aunt) Male Relative (e.g. grandpa, uncle)
 Unrelated female adult Unrelated male adult Mother's Live-in partner Father's Live-in partner Other

ADDRESS FOR HOME VISITS

Will the home visits take place at the child's physical address in CFCR?

- Yes No Unknown at this time

If 'No,' enter the address below.

Address for Home Visits (different from Child's physical address in CFCR)

Street 1: _____

Street 2: _____ **APT/Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Zip + 4:** _____

REASONS FOR RFS

REASONS FOR RFS: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY) | <input type="checkbox"/> Child exposure to community violence | <input type="checkbox"/> Major child/family health concerns |
| <input type="checkbox"/> Child developmental/educational concerns | <input type="checkbox"/> Child abuse/neglect | <input type="checkbox"/> Parent/caregiver mental health concerns |
| <input type="checkbox"/> Child behavioral/emotional concerns (Home) | <input type="checkbox"/> Need for parenting education | <input type="checkbox"/> Parent/caregiver substance abuse |
| <input type="checkbox"/> Child behavioral/emotional concerns (School or Child Care) | <input type="checkbox"/> Imminent risk of or recent out-of-home placement | <input type="checkbox"/> Parent/caregiver educational needs |
| <input type="checkbox"/> Child exposure to domestic violence | <input type="checkbox"/> Risk of or recent child expulsion from child care or school | <input type="checkbox"/> Service coordination needs |
| | <input type="checkbox"/> Homelessness or risk of family eviction | <input type="checkbox"/> RFS Source did not identify a reason |
| | | <input type="checkbox"/> None/none listed |
| | | <input type="checkbox"/> *Other (please describe) |

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Birth to Three
<input type="checkbox"/> Court personnel
<input type="checkbox"/> Child welfare – Investigation
<input type="checkbox"/> Child welfare – Alternative services
<input type="checkbox"/> Public support services (e.g. Social services, developmental services)
<input type="checkbox"/> Public health services (WIC, Healthy Start)
<input type="checkbox"/> Domestic violence agency or shelter
<input type="checkbox"/> Early Childhood Consultation Partnership (ECCP)
<input type="checkbox"/> Early childhood education/childcare | <input type="checkbox"/> Emergency Mobile Psychiatric Service (EMPS)
<input type="checkbox"/> Faith based organization
<input type="checkbox"/> Family resource & support center
<input type="checkbox"/> Health provider – adult
<input type="checkbox"/> Health provider – pediatric
<input type="checkbox"/> Home visiting (Nurturing Family, PAT, EHS, NFP)
<input type="checkbox"/> Hospital – Emergency Room (ER)
<input type="checkbox"/> Hospital – Obstetrics | <input type="checkbox"/> Mental health provider - adult
<input type="checkbox"/> Mental health provider - child
<input type="checkbox"/> Regional Education Service Center (RESC)
<input type="checkbox"/> Shelter – family
<input type="checkbox"/> Substance abuse program
<input type="checkbox"/> None/none listed
<input type="checkbox"/> *Other (please describe)
_____ |
|---|---|---|

REASONS FOR RFS NARRATIVE:

*Please include events that led to the referral, other agencies involved with the family, and whether the family has previous history with Child First if applicable.

I _____, Legal Guardian of _____, give permission for this referral to be sent to the Child First affiliate agency _____ and for information to be sent to the Child First National Program Office. I understand that I will be contacted by the Child First affiliate agency directly to learn more about Child First and if it is an appropriate service for my child and my family.

Legal guardian signature: _____

Date: _____

Referent signature: _____

Date: _____