Project Family, LLC

Building families one member at a time……

DFCS REFERRAL FORM

Referral Date (xx/xx/xxxx)

DFCS County of Referral, and Case Number

Case Name (Biological Mother), DOB, and Phone Number

Address (street, city, zip)

Ethnicity & Primary Language:

Marital Status (Include spouse or significant other Name and DOB here)

Name & Address of Client receiving services (if different from birth mother listed above)

DFCS SSCM Name, Phone, E-mail

Child(ren) Name, Gender, DOB, and school attended (If not in school, please note n/a)

Child(ren)'s Placement Information (Names, Address, Phone) and Date Child(ren) were Removed from their home.

If biological father is known, please provide Name, DOB, and any contact information here (unless this information has been provided in a previous section)

List any family members that receive Medicaid and include their Medicaid number or Social Security number (N/A if none)

List Services Requested (include frequency and length of service requested)

Provide a brief background, and an explanation of why these services have been requested:

Please notify us immediately of any changes to the case contact information, case management, services requested, or case plan.

For your convenience, you may E-mail this referral to Tina Lawrence at tina.projectfamily@gmail.com, or you may also Fax your referral to 1-888-334-4283