



Parent Partner Program

Participant Profile Referral/Intake Form

Referral/Intake Information

<b>Referral/Intake Information</b>	
Person Making Referral	Date of Referral
Email	Phone
Referral Agency: <input type="checkbox"/> HHS <input type="checkbox"/> Self <input type="checkbox"/> Other	
Does the participant know a referral is being made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Release signed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for referral:	
Has the participant attended a Family Focused Meeting (FFM)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of FFM (if different from referral date)	Time of FFM
Current concerns: <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Substance Use <input type="checkbox"/> Mental Health – Participant <input type="checkbox"/> Housing <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Mental Health – Child(ren) <input type="checkbox"/> Child(ren) Supervision <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Other:	
HHS Worker (if different from “Person Making Referral”):	
Email:	Phone:

<b>Participant Information</b>	
Referred Participant Name (Last, First)	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Participant FACS ID#	Date of birth
Youngest Child FACS ID#	
Primary Phone Number	Alternate Phone Number
Current Address (Street Address, City, State, ZIP Code)	
County	Email

(Turn over for page 2)

<b>Participant's Family Information</b>	
Other Participant Name (Last, First):	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Has this participant been referred to the PP program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this participant share custody of children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Explain:	
Email:	Phone:
Is this case considered: <input type="checkbox"/> In-home support <input type="checkbox"/> Out-of-home placement support**	
If in-home support:	
Date of initial Child Safety Conference (CSC)	Date of follow-up CSC:
If out-of-home placement support, date and reason:	

\*\*This includes parents who can only reside with their children under special conditions directed by the courts (e.g., substance use treatment or relative care).

Children's placement information:		
Has this participant had prior involvement with HHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, when and why?		
Date of next FFM	Time	Location
Date of next court date	Time	Location

Full name of Participant Member	Relationship	Date of Birth (MM/DD/YY)	Sex (M/F)	Race*	Hispanic/Latino Heritage (Y/N)
	Participant (Self)				

\*Mark all that apply. American Indian/Alaska Native (A/AN), Black/African-American (B), White (W), Asian (A), Native Hawaiian/Other Pacific Islander (NH/PI), Don't Know (DK), Refused (R), or Other – specify.

**(See page 3)**

<b>Attempts to contact Participant</b>		
Date	Type (Phone, email, Face-to-Face)	Comments

Result of Referral:

Client accepted     Client declined support     Client not appropriate for support

PP Assigned (Name)	Date
Date of entry of intake in database:	Date of intake completion