



*DATE OF REQUEST FOR SERVICE:
____/____/____



Coastal Horizons
COMMUNITY BASED FAMILY SERVICES

Child First Staff Initials: _____

Transforming Lives



REQUEST FOR SERVICE

**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:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Entry Agency – Healthy Mothers Healthy Babies (HMHB) **
<input type="checkbox"/> Entry Agency – Homesafe (HSAFE) **
<input type="checkbox"/> Self (Caregiver or family) *
<input type="checkbox"/> Birth-to-Three
<input type="checkbox"/> Court Personnel
<input type="checkbox"/> Child Welfare/Child Protective Services
<input type="checkbox"/> Child Developmental Services Provider
<input type="checkbox"/> Domestic Violence Agency or Shelter
<input type="checkbox"/> Early Head Start | <input type="checkbox"/> Early Childcare Provider/Partnership
<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 – Obstetric/adult
<input type="checkbox"/> Health provider – Pediatric
<input type="checkbox"/> Mental Health Provider – Adult | <input type="checkbox"/> Mental Health Provider – Child
<input type="checkbox"/> Pedi PCC
<input type="checkbox"/> Other home visiting (e.g. PAT, ICAPS)
<input type="checkbox"/> Public Health Service/Department
<input type="checkbox"/> School System
<input type="checkbox"/> Shelter
<input type="checkbox"/> Social Services
<input type="checkbox"/> Substance Abuse Program
<input type="checkbox"/> 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 / PHP
- 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"/> Emergency Mobile Psychiatric Service (EMPS) | <input type="checkbox"/> Mental health provider - adult |
| <input type="checkbox"/> Court personnel | <input type="checkbox"/> Faith based organization | <input type="checkbox"/> Mental health provider - child |
| <input type="checkbox"/> Child welfare – Investigation | <input type="checkbox"/> Family resource & support center | <input type="checkbox"/> Regional Education Service Center (RESC) |
| <input type="checkbox"/> Child welfare – Alternative services | <input type="checkbox"/> Health provider – adult | <input type="checkbox"/> Shelter – family |
| <input type="checkbox"/> Public support services (e.g. Social services, developmental services) | <input type="checkbox"/> Health provider – pediatric | <input type="checkbox"/> Substance abuse program |
| <input type="checkbox"/> Public health services (WIC, Healthy Start) | <input type="checkbox"/> Home visiting (Nurturing Family, PAT, EHS, NFP) | <input type="checkbox"/> None/none listed |
| <input type="checkbox"/> Domestic violence agency or shelter | <input type="checkbox"/> Hospital – Emergency Room (ER) | <input type="checkbox"/> *Other (please describe) |
| <input type="checkbox"/> Early Childhood Consultation Partnership (ECCP) | <input type="checkbox"/> Hospital – Obstetrics | _____ |
| <input type="checkbox"/> Early childhood education/childcare | | _____ |

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: _____

PLEASE RETURN TO: Fax completed referral forms to 910-202-5772 (Attention: Child First). Cases may be staffed with Child First Supervisors (910) 202-3155
For more information, please contact us at cbfsadmin@coastalhorizons.org.