DATE OF REFERRAL: Date assigned: ___/___/____
___/___/___ Date opened: ___/___/____
Child First Staff Initials: ______

Intercommunity Inc.
E. Hartford/Manchester
REQUEST FOR SERVICE

CHIL...
**REFERRAL INFORMATION**

Please describe the concerns that have led to this referral: *Please also indicate if referral is urgent and why.*

*If DCF referral, please indicate status and goals.*

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Reasons for Referral: (Check all that apply)

☐ Basic needs (e.g., housing, heat, food, TANF, SNAP, HUSKY)

☐ Child developmental/educational concerns

☐ Child behavioral/emotional concerns

☐ Child exposure to violence

☐ Child abuse/neglect

☐ Risk of child out-of-home placement

☐ Risk of child expulsion from school

☐ Risk of family eviction

☐ Major child/family health concerns

☐ Parent/caregiver mental health

☐ Parent/caregiver substance abuse

☐ Parent support and education needs

☐ Service coordination needs

☐ Other (please specify): ____________________________

Other Services/Agencies Currently Involved with Child/Family: (Check and circle program if appropriate)

☐ Birth to Three

☐ Court personnel

☐ Dept of Children and Families (DCF)

☐ DCF – Home-based service (IFP, FBR, IICAPS, FES-Triple P, Caregiver Support Team, other ____________________________)

☐ DCF – Care Coordination

☐ Dept of Developmental Services (DDS)

☐ Dept of Social Services (DSS)

☐ Dept Mental Health & Addiction Serv (DMHAS)

☐ Domestic violence agency or shelter

☐ Early Childhood Consultation Partnership (ECCP)

☐ Early childhood education/childcare

☐ Emergency Mobile Psychiatric Service (EMPS)

☐ Faith based organization

☐ Family resource & support center

☐ Health Department (WIC, Healthy Start)

☐ Health provider – adult

☐ Health provider – pediatric

☐ Help Me Grow

☐ Home visiting (Nurturing Family, PAT, EHS, NFP)

☐ Hospital – Emergency Room (ER)

☐ Hospital – Obstetrics

☐ Mental health provider - adult

☐ Mental health provider - child

☐ Regional Education Service Center (RESC)

☐ Shelter – family

☐ School System – Special Education

☐ Substance abuse program

☐ Other ______________________

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: __________________________

Referrant signature: __________________________________________ Date: __________________________

**PLEASE RETURN TO:**

Alaina Crawford
alainacrawford@intercommunityct.org
fax: 860-291-1396

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