



FAMILIES FIRST PROGRAM
Intensive In-Home Family Services
Referral Form

Official Use Only
Assigned Worker: Family Number:
Date Case Assigned: Start Date:

Person Making Referral: Date:
Agency: Phone:
Address to Send Reports:
Email Address:
How did you hear about Families First?:

Referred Child/Youth: Juvenile Court Number:
Address: City:
Zip Code: Home Phone: Date of Birth:
Age: Sex: M F Court Status: Language Preference:
School: Other Programs Youth Involved in:

(Please check [✓] if person is living at home of the youth.)

Mother's Name: Mother's Work Phone: Mother's Cell Phone:
Father's Name: Father's Work Phone: Father's Cell Phone:
Step Parent/Guardian: Date of Birth:
Parent/Guardian Work/Cell Phone(s):

Diagnosis: Axis I Code
Axis II
Axis III
Axis IV
Axis V

List all children in home by age.

Name: Age: Date of Birth:
Name: Age: Date of Birth:
Name: Age: Date of Birth:
Name: Age: Date of Birth:
Name: Age: Date of Birth:

Other people in home:

Name: Relationship: Date of Birth:
Name: Relationship: Date of Birth:

The parents understand that the Families First service is a minimum of six weeks and eight hours per week in the family's home. Yes No

Family Schedule:

Work: Mon. _____ Tues. _____ Wed. _____ Thur. _____
 Fri. _____ Sat. _____ Sun. _____
Vacation: _____

History of Referred Child/Youth:

Prior Out Patient? Yes No How Long? _____ With Whom? _____
Is the above Person Recommending Residential Treatment? Yes No
Prior Acute Care? Yes No When? _____ Where? _____
Reason for Acute Care: _____

Where is the child at the time of this referral? _____

If the child is not in the home, can he/she be returned home within 7 days? Yes No
Please explain: _____

Problem Checklist: (Please check [✓] any of the following problems that you think the family/ child is experiencing. Also, please identify persons involved and provide a description regarding the degree of the problem in the space below.)

Continuing Problems - Family

- AB Abuse/exploitation by non-family member
- DA Parent drug/alcohol problem
- EA Emotional abuse by a parent
- FV Family violence
- IL Parent handicap/illness
- IR Inadequate physical resources
- NG Neglect
- PA Physical abuse by parent
- PC Parent-Child conflict
- RS Parent too restrictive/protective
- SA Sexual abuse by parent
- UE Parent unemployment

Continuing Problems – Target Child(ren)

- AA Alcohol abuse
- BP Behavior problems/ delinquent
- CC Custody change
- DP Depressed
- DR Drug abuse
- HH Health problem/handicap
- LD Learning disability
- MI Mental/emotional illness
- MR MR/DD
- PG Pregnancy/unwed
- RW Runaway
- SP Suicide potential
- SX Sexual acting out
- TR Truancy

Please Explain: _____

What do you expect the Families First Specialist to accomplish? _____

PRIMARY INSURANCE

Policy Holder: _____ SS#: _____ DOB: _____
Relationship to Insured: _____
Employer: _____ Group #: _____
Insurance Company: _____ Phone #: _____
Effective Date: _____ Exclusions/Restrictions: _____
Benefits: _____% OOP: _____ Ded: _____ CYM: _____ Verified By: _____
Notes: _____

SECONDARY INSURANCE

Policy Holder: _____ SS#: _____ DOB: _____
Relationship to Insured: _____
Employer: _____ Group #: _____
Insurance Company: _____ Phone #: _____
Effective Date: _____ Exclusions/Restrictions: _____
Benefits: _____% OOP: _____ Ded: _____ CYM: _____ Verified By: _____
Notes: _____

NOTES/FOLLOW-UP

Please Fax to: Utah Youth Village c/o Sheila Gledhill (866) 546-3865 (Sheila) (801) 272-9976 (Village)	Mailing Address:	Utah Youth Village 5800 Highland Dr. Salt Lake City, Utah 84121 (801) 272-9980
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