

CPO Approval: \_\_\_\_\_



**JUVENILE COURT  
FAMILIES FIRST PROGRAM  
Intensive In-Home Family Services Referral Form**

**Official Use Only**  
Assigned Worker: \_\_\_\_\_ Family Number: \_\_\_\_\_  
Date Case Assigned: \_\_\_\_\_ Start Date: \_\_\_\_\_

Referring Probation Worker: \_\_\_\_\_ Date: \_\_\_\_\_  
Probation Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address to Send Reports: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Court Status: \_\_\_\_\_ Language Preference: \_\_\_\_\_ School: \_\_\_\_\_

Referred Youth: \_\_\_\_\_ Juvenile Court Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: M F Other Programs Youth Involved in: \_\_\_\_\_

*(Please check [✓] if person is living at home.)*

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

**List all children in home by age.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Other people in home:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Probation Officer explained the Families First program to the parent/guardian previous to submitting this referral and 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. \_\_\_\_\_

Planned Vacation: \_\_\_\_\_

Where is the child at the time of this referral? \_\_\_\_\_

If the youth 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/ youth 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

Contributing Problems – Target Youth

- 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: \_\_\_\_\_

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What do you expect the Families First Specialist to accomplish? \_\_\_\_\_

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Please put PRA information here: (CARE Dynamic Items & Case Plan)

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