



Referral Form (Page 1)

House Bill 1451 Family Advocacy Support Team Referral Form
Serving ages 5-18 with complex needs

Date of Referral: _____

Date Received: _____

Referral Source:

*Name: _____ *Organization: _____

*Phone: _____ Fax: _____ Email: _____

Family Informed of referral: YES (Referred families MUST be informed of the referral. If they are not, the referral will not be accepted)

Child Information:

*Name: _____ *DOB: _____ Age: _____

*Gender: _____ *Primary Language: _____ Insurance Information: Medicaid Uninsured HMO/PPO/Other

*Ethnicity: Caucasian Cora Hispanic Asian African American Native American Other: _____

School: _____ Grade: _____ Special Education? : YES NO

Parent/Guardian Information:

1. *Relation to the Child: Parent Relative Foster Parent Legal Guardian Other: _____

*Name: _____

*Home Address: _____ *City: _____ State: _____ Zip: _____

*Phone: _____ Alt. Phone: _____ Email: _____

2. Relation to the Child: Parent Relative Foster Parent Legal Guardian Other: _____

Name: _____

Phone: _____ Alt. Phone: _____ Email: _____

Household Information:

Name	Date of Birth	Gender
1.		
2.		
3.		
4.		

Special Accommodation Needs, if any (i.e. interpreter, physical or sensory disabilities, medical needs, limitations, etc.):

Please see reverse side and complete

* Incomplete referrals will be returned, referrals will not be screened until referral form is filled out completely



Referral Form (Page 2)

Current Reason(s) for Referral:

***"Why Now?"** Give a short description on why the referral is being made now:

***Precipitating Events?** Give a short description of events leading to this referral:

Additional Information/Reasons. Please provide any information regarding why you are making this referral. Include anything that applies to School, Placement, Legal issues, Drug and/or Alcohol Use, Issues at Home, Safety Concerns, Mental Health and Diagnosis or other extenuating circumstances.

Current Agency Involvement:

*Select all agencies the child and/or family is already involved with and provide the contact name & number for each agency you select below

DHS – Child Welfare

Contact: _____

School Services

Contact: _____

DYC (Department of Youth Corrections)

Contact: _____

Health Services

Contact: _____

Mental Health Services

Contact: _____

Gunnison Valley Mentors

Contact: _____

Juvenile Diversion

Contact: _____

Project Hope

Contact: _____

Probation

Contact: _____

DVR (Department of Vocational Rehabilitation)

Contact: _____

Additional Information/Strengths/Interests: _____

Form to be completed by referral agency and submitted to:

Family Advocacy and Support Team (FAST) Coordinator:

Address: 200 E. Virginia Ph: 641-7665 Fax: 641-9079 E-mail: fastcoordinator@gunnisoncounty.org