# Referral Form (Page 1)

**House Bill 1451 Family Advocacy Support Team Referral Form**
**Serving ages 0-21 with complex needs**

Date of Referral: _____ Date Received: _____

**Referral Source:**
Name: _____ Organization: _____
Phone: _____ Fax: _____ Email: _____
Family Informed of referral: __ YES __ NO (referring agency has contacted the family introduced FAST and informed them of the referral)

**Child Information:**
Name: _____ DOB: _____ Age: _____
Gender: __ **M** __ **F**
Ethnicity: ___African American ___Asian ___Caucasian ___ Cora ___ Hispanic ___Native American ___Other: _____
Primary Language: _____
Insurance Information: Medicaid: Y__ N __ Other: _____

**Parent/Guardian Information:**
Name: _____ ☐ Parent ☐ Relative ☐ Foster Parent ☐ Legal Guardian
Address: _____ Apt #:_____ Phone: _____ Alt. Phone: _____
City: _____ State: _____ Zip: _____ Email: _____

**Siblings/Children Living in Household:**
1. _____ D.O.B. _____ M F _____
2. _____ D.O.B. _____ M F _____
3. _____ D.O.B. _____ M F _____
4. _____ D.O.B. _____ M F _____

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

**School _____ Grade_____ Special Ed. ☐ Y ☐ N**

**Current reasons for referral (please explain):**
"Why Now?"_____
Precipitating Events?_____
☐ School? _____
☐ Placement? _____
☐ Legal?_____
☐ Drugs and/or Alcohol? _____
☐ Home? _____
☐ Safety? _____
☐ Mental Health? _____
☐ Diagnosis? _____
☐ Other _____

**Please see reverse side and complete**
**** Incomplete referrals will be returned, referrals will not be screened until referral form is filled out completely**

F.A.S.T.

# Referral Form (Page 2)

**Eligibility (Child is involved with at least two of the following partnering agencies):**

*** Please check all that apply and add contact name.**

- ☐ DHS _____
- ☐ DYC _____
- ☐ Mental Health _____
- ☐ Juvenile Services _____
- ☐ Probation _____
- ☐ School _____
- ☐ Health _____
- ☐ Gunnison Valley Mentors_____

**Additional Information/Strengths/Interests:** _____

_____

_____

**ISST/Wrap members identified:**

Family Facilitator: _____

Other as appropriate: _____

Natural Supports: _____

**Resources Consideration** (*Check or define need or what currently is in place):*

| | Currently provided | Needed | Suggested |
|---|---|---|---|
| Medical | | | |
| Dental | | | |
| Housing | | | |
| Clothing | | | |
| Food | | | |
| Tutoring | | | |
| Mentoring | | | |
| Transportation | | | |
| Other | | | |

**For approval referral must include:**

____ Intake Assessment

____ Multiple-agency release of information form

____ Substance Abuse consent to release (if applicable)

**Other Information Attached** (Check appropriate additional information provided)

____ School Information

____ Health / Mental Health Information (circle as applicable)

____ Law Enforcement / Judicial System History

*Form to be completed by referral agency/person and submitted to:*

***Meghan Dougherty***

*Family Advocacy and Support Team (FAST) Coordinator:*

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