CCC In-Home Based Services (IHBS)
Community Partner/Self Referral Form

Date of Referral: _____

☐ CCC In-Home Based Services (IHBS) – low risk cases only

Family Name: _____ **Case Number ():**_____

Family's Address: _____ **County:** _____

Family's Phone Number:_____

Is the family aware that this referral is being made and given a description of each program? ☐ **Yes** ☐ **No**

Parent has signed a release form for CCC IHBS)? ☐ **Yes** ☐ **No** **Date:** _____
(Note: All referrals require a signed release forms listing all providers for approval)

Parent/guardian/caretakers:

Name	DOB	SS#	Relationship/Role	Willing to work with In-Home Services	
				☐	
				☐	

Children: (indicate check under referred child if the child is at risk of placement or in need of reunification svc)

Name	DOB	SS#	Gender	Referred child		Referred Child currently in home
				☐		☐
				☐		☐
				☐		☐
				☐		☐

Other Household Members:

Name	DOB	SS#	Relationship/Role	To be involved with In- Home services
				☐
				☐

If the caretaker/guardian listed above is not the parent please provide the information requested below.

Mother: Involved w/child? ☐ Y ☐ N Address: Phone:
Father: Involved w/child? ☐ Y ☐ N Address: Phone:

Reason for Referral: (Explanation of situation/factors which places the child(ren) at risk of placement or resulted in the removal of the child(ren) from his parents' care. Include behaviorally specific information about all individuals contributing to the risk of removals.) (For CCC IHBS- describe need for In-home services.)

Services Needed: (Referring worker's recommended treatment goals or services to be provided by the in-home provider)

Presenting Problems: (what are the specific behaviors or issues that need CCC in-home services) ***Please check all that apply****

Presenting Parent/Family Issues	Past	Present	Both	Comments (Specify individual, severity, treatment, etc.)
Alcohol Use – Parent	☐	☐	☐	
Divorce / Single Parent Issues	☐	☐	☐	
Domestic Violence	☐	☐	☐	
Drug Use – Parent	☐	☐	☐	
Mental Health Issues – Parent	☐	☐	☐	
Poor Parenting Skills	☐	☐	☐	
Criminal History – Parent	☐	☐	☐	
Limited Cognitive Functioning	☐	☐	☐	
Child Physical Abuse	☐	☐	☐	
Child Sexual Abuse	☐	☐	☐	
Child Neglect	☐	☐	☐	

Presenting Child/ren Issues	Past	Present	Both	Comments (Specify individual, severity, treatment, etc.)
Aggression	☐	☐	☐	
Alcohol Use – Child	☐	☐	☐	
Behavior Problems at Home	☐	☐	☐	
Criminal Activity	☐	☐	☐	
Developmental Delays	☐	☐	☐	
Drug Use – Child	☐	☐	☐	
Gang Issues	☐	☐	☐	
Medication(s)	☐	☐	☐	
Mental Health Issues – Child	☐	☐	☐	
Pregnancy	☐	☐	☐	
Relative Placement	☐	☐	☐	
School Problems – Academic	☐	☐	☐	
School Problems – Behavioral	☐	☐	☐	
Self-Harm	☐	☐	☐	
Suicidal Ideation	☐	☐	☐	
Truancy	☐	☐	☐	
Child Physical Abuse	☐	☐	☐	
Child Sexual Abuse	☐	☐	☐	
Child Neglect	☐	☐	☐	
Other (please specify):	☐	☐	☐	

- Are there mental health concerns of anyone in the home? If so, please explain
- Is there current or past court involvement (Abuse, Neglect, Dependency or Juvenile/Status) with the referred child/ren? If so, please explain.
- Are there other significant issues in the family? (medical problems, hearing impaired, mobility issues, etc)
- Identify family strengths.
- Are any of the following providers currently involved with this family and provide name of the provider/case manager.

☐ Every Child Succeeds _____
☐ Impact _____
☐ Mental Health Provider _____
☐ Department for Juvenile Justice (DJJ) _____
☐ First Steps _____
☐ Impact Plus _____
☐ Other, specify _____

If DJJ is involved please provide an explanation of the type of type of involvement.

Referring Worker: _____ **Email address:_____** **Phone/ext: _____**

Office Use:
☐ **Approved, Date: _____** ☐ **Pending, end date: _____** ☐ **Denied**

Program Approved: ☐ **CCC In-Home Based Service (IHBS)**

Referral Received: _____

Referral Accepted: _____

Referral Source Notified of Approval Status: _____

Comments:
_____
_____
_____
_____
_____