

DATE OF REQUEST FOR
SERVICE:

____/____/____

Request for Service (RFS)

Child First Staff Initials: _____



NAME OF PERSON REQUESTING CHILD FIRST:

Last Name: _____ First Name: _____

Telephone: Office: _____ Mobile: _____

RFS SOURCE TYPE:

- | | | |
|--|--|---|
| ☐ Self (Caregiver or family) * | ☐ Faith based organization | ☐ School System |
| ☐ Birth-to-Three | ☐ Family resource & support center | ☐ Shelter |
| ☐ Court Personnel | ☐ Health Provider – Obstetric/adult | ☐ Social Services |
| ☐ Child Welfare/Child Protective Services | ☐ Health provider – Pediatric | ☐ Substance Abuse Program |
| ☐ Child Developmental Services Provider | ☐ Mental Health Provider – Adult | ☐ Other _____ |
| ☐ Domestic Violence Agency or Shelter | ☐ Mental Health Provider – Child | |
| ☐ Early Head Start | ☐ Pedi PCC | FL Only: |
| ☐ Early Childcare Provider/Partnership | ☐ Other home visiting (e.g. PAT, ICAPS) | ☐ Healthy Mothers/Healthy Babies |
| ☐ Emergency Mobile Psychiatric Service | ☐ Public Health Service/Department | ☐ Homesafe |

INDIVIDUAL BEING REFERRED TO CHILD FIRST:

Name: _____

Street 1: _____

Street 2: _____

APT/Suite: _____

City: _____ State: _____ Zip: _____ Zip +4: _____

DOB: (MM/DD/YYYY) ____/____/____ GENDER: ☐ Male ☐ Female ☐ Non-binary

PRONOUNS: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs

RACE: (Check all that apply)

- ☐ Black or African-American
- ☐ White/Caucasian
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Hispanic or Latinx
- ☐ Middle Eastern or North African
- ☐ Other/Not Listed

ETHNICITY: (Check all that apply)

- ☐ Non-Hispanic, Non-Latino, Not of Spanish origin
- ☐ Hispanic – Mexican (or Mexican American, Chicano)
- ☐ Hispanic – Puerto Rican
- ☐ Hispanic – Cuban
- ☐ Hispanic – South or Central American
- ☐ Hispanic – Other
- ☐ Unknown
- ☐ Non-Hispanic – Haitian
- ☐ Non-Hispanic – Caribbean

PRIMARY LANGUAGE:

- | | | |
|---|--|---|
| ☐ English | ☐ Chinese, Mandarin | ☐ Non-Verbal |
| ☐ Spanish | ☐ Farsi | ☐ Polish |
| ☐ French Creole | ☐ French | ☐ Pre-Verbal |
| ☐ Portuguese | ☐ Gujarathi | ☐ Russian |
| ☐ American Sign Language | ☐ Khmer | ☐ Serbo-Croatian |
| ☐ Armenian | ☐ Korean | ☐ Vietnamese |
| ☐ Chinese, Cantonese | ☐ Laotian | ☐ Other: |

OTHER LANGUAGE:

- | | | |
|---|--|---|
| ☐ English | ☐ Chinese, Mandarin | ☐ Non-Verbal |
| ☐ Spanish | ☐ Farsi | ☐ Polish |
| ☐ French Creole | ☐ French | ☐ Pre-Verbal |
| ☐ Portuguese | ☐ Gujarathi | ☐ Russian |
| ☐ American Sign Language | ☐ Khmer | ☐ Serbo-Croatian |
| ☐ Armenian | ☐ Korean | ☐ Vietnamese |
| ☐ Chinese, Cantonese | ☐ Laotian | ☐ Other: |

ADMISSION TYPE

☐ Child at admission ☐ Pregnant at admission

If 'Child at admission':

Is the caregiver to be involved in services with the index child the person requesting services? ☐ Yes ☐ No

If 'No':

Full name of Caregiver to be involved in services: _____

Address: _____

Phone: _____

Relationship to child: ☐ Birth Father ☐ Birth Mother ☐ Foster Mother ☐ Foster Father ☐ Step Mother
☐ Step Father ☐ Adoptive Mother ☐ Adoptive Father ☐ Female Relative (e.g. grandma, aunt) ☐ Male Relative (e.g. grandpa, uncle)
☐ Unrelated female adult ☐ Unrelated male adult ☐ Mother's Live-in partner ☐ Father's Live-in partner ☐ Other

If 'Pregnant at admission' (For 'Pregnant at admission' it is preferable that the pregnant caregiver begins Child First no earlier than 20 weeks of pregnancy)

Number of weeks gestation: _____

ADDRESS FOR HOME VISITS

Will the home visits take place at the client's physical address?

☐ Yes ☐ No ☐ Unknown at this time

If 'No,' enter the address below.

Address for Home Visits (different from Child's physical address in CFR) _____

Street 1: _____

Street 2: _____ APT/Suite: _____

City: _____ State: _____ Zip Code: _____ Zip + 4: _____

REASONS FOR RFS: (Check all that apply. Relevancy may be based on admission type.)

- | | | |
|--|---|---|
| ☐ Basic needs (e.g., housing, heat, food, TANF, SNAP) | ☐ Imminent risk of or recent out-of-home placement | ☐ RFS Source did not identify a reason |
| ☐ Developmental/educational concerns | ☐ Homelessness or risk of family eviction | ☐ None/none listed |
| ☐ Exposure to domestic violence | ☐ Physical health concerns | ☐ Other (please describe): _____ |
| ☐ Exposure to community violence | ☐ Mental health concerns | _____ |
| ☐ Child abuse/neglect | ☐ Substance abuse | _____ |
| ☐ Need for parenting education | ☐ Service coordination needs | |

OTHER SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD/FAMILY: (Check all that apply)

- | | | |
|--|---|---|
| ☐ Birth to Three | ☐ Faith based organization | ☐ Public health service/department |
| ☐ Court personnel | ☐ Family resource & support center | ☐ School System |
| ☐ Child welfare/child protective services | ☐ Health provider – obstetric/adult | ☐ Shelter |
| ☐ Child developmental services provider | ☐ Health provider – pediatric | ☐ Social services |
| ☐ Public health services (WIC, Healthy Start) | ☐ Mental health provider - adult | ☐ Substance abuse program |
| ☐ Domestic violence agency or shelter | ☐ Mental health provider - child | ☐ None/none listed |
| ☐ Early childhood provider/partnership | ☐ Pedi PCC | ☐ Other (please describe) _____ |
| ☐ Emergency Mobile Psychiatric Service | ☐ Other home visiting (e.g., PAT, ICAPS) _____ | |

REASONS FOR RFS NARRATIVE:

Please include events that led to the referral, other agencies involved with the client/family, and whether the client/family has previous history with Child First if applicable.

I _____, legal guardian of _____, give permission for this referral to be sent to the Child First affiliate agency _____ and for information to be sent to the Child First National Program Office. I understand that I will be contacted by the Child First affiliate agency directly to learn more about Child First and if it is an appropriate service for my child and my family.

Legal guardian signature: _____

Date: _____

Referent signature: _____

Date: _____

Send completed referral to childfirst@phmc.org or by confidential fax at 267-592-4068