

**Community Case Management Referral Form**

**THIS FORM IS *NOT* FOR CONCERNS OF CHILD ABUSE OR NEGLECT. IF A CONCERN REACHES THE LEVEL OF CHILD ABUSE OR NEGLECT, PLEASE CALL 1-844-CO-4-KIDS TO REPORT THE CONCERNS.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Identified Child ‘s Name:**  |   | **DOB:** |   |
| **Name of Caregiver:**  |   | **DOB:**  |   |
| **Relation:**  |   |  |
| **Other Adults/Caregivers in the Home (***Include DOB***):**   |
|   |
| **Primary Address:**  |   |[ ]  **Homeless?** |
| **City:** |   | **State:** |  CO  |  |
| **Zip:**  |   |  |
| **Primary Phone Number:**  |   |  |
| **Cell Phone Number:**  |   | **Contact:** |   |
| **Alternate Phone Number:**   | **Contact:**  |   |
| **Email Address:**   |  |
| **Preferred Language of Family:**  |[ ]  **English** |[ ]  **Spanish** |[ ]  **Other:**  |   |
| **School:**  |   | **Grade:**  |   |
| **Referral Source:**  |   | **Contact #:**  |   |
|  |  |  |  |
| **How many children are currently in the home?**  |   |  |
| **Other Children in the Home (***Include DOB***):**   |
|   |

**Did you inform the family that you are referring them to the *Compass/Prevention* Program?** [ ]  Yes [ ]  No

 Primary reason for initial referral:

[ ]  **Assaultive** [ ]  **Delinquency** [ ]  **Disobedience** [ ]  **Gangs** [ ]  **Mental Health**

[ ]  **Runaway** [ ]  **Substance Abuse** [ ]  **Suicidal** [ ]  **Truancy** [ ]  **Medical**

[ ]  **Disability** [ ]  **Other:** Click or tap here to enter text.

|  |  |
| --- | --- |
| **Narrative:** |  |
|  |
|  |

 **What Next:**

* Please email this completed form to HS-Prevention-Referral@co.weld.co.us
* The Prevention Team reviews all referrals to determine program eligibility once a week.
* If the referral is assigned, the Case Manager will contact the family to see if they would like services.