The Center for Healthy Families
Building Bridges to Brighter Futures

Date referral received____________
Date referral entered_____________

HEALTHY FAMILIES CONNECTION - REFERRAL FORM

IDENTIFYING INFORMATION **Today's Date** ______________________

1. Name: ______________________ ______________________ _______ Date of Birth: __________
Last *First* *M.I.*

□ Male □ Female Age: _________ Race: _______________ County of Residence________________

☐ Pregnant Due date: ______________ ☐ Parenting: No. of children: ______ Child DOB: #1_________ #2 _________ #3 ________

School: ______________________________ Grade: _________ Email:______________________________

2. Parent/Legal Guardian Name: ____

Address:____
Street *City* *State* *Zip Code*

Teen Phone: ____________________ Parent/Guardian Phone: ____________________ Other Phone:____________

With whom does the teen live? □ Both Parents □ Father □ Mother □ FCCS Placement □ Other:______________

If the teen lives with someone other than the person who has legal custody of him/her, please complete the following:

Name and relationship of who teen lives with: ____

Address:____
Street *City* *State* *Zip Code* *County*

Other Phone: (Name/relationship to teen)______________________ Phone Number:____________________

Agency Contact Person: ____________________________________ **Email Address:**_____________________

Referral Agency/Address: ____ **Phone:** ________________

Does participant have Franklin County Children Services involvement presently or in the past? _________

ELIGIBILITY DETERMINATION
Criteria
□ age 13-19 □ Franklin County Residence
□ Documented Citizen (specify document) ______________________ □ Yes □ No (If no, specify): ____________________

Specific Areas of Concern (REQUIRED) ____

What caused case opening?____
Young adults' current status to case plan goals:____
____

What are the primary concerns that brought the participant to Healthy Families Connections? (Choose all that apply)
□ Healthy Baby □ Housing Safety/ Stability □ Relationship concerns □ Subsequent pregnancies
□ Education □ Parenting Skills □ Employment □ Other: ____________________________

If the referral is not from the parents, has the referral been discussed with the family? □ Yes □ No □ N/A

_________________________________ _________________________________
Referral Representative Signature and Date HFC Staff Signature and Date

To view our Resource Directory, click here.