The Center for Healthy Families
Building Bridges to Brighter Futures

For Internal Use Only:
HFC HFA
Date referral received
Date referral entered

HEALTHY FAMILIES CONNECTION REFERRAL FORM

Today's Date:

Name: D.O.B:

Male Female Age : Race: County of Residence:

Pregnant Due Date: Parenting Number of children:

Child DOB #1 #2 #3

School: Grade: Email:

Parent/Legal Guardian Name: Parent/Legal Guardian Phone:

Youth Current Address:

Youth Phone: Other Phone:

With whom does the Youth live? Both Parents Father Mother FCCS Placement Other:

Has the referral been discussed with the Youth's parent(s/guardian(s)? Yes No

Does the Youth presently have Franklin County Children's Services involvement? Yes No

Specific Areas of Concern (REQUIRED) **Choose all that apply:**

Domestic/Inter-Personal Violence Education Employment Healthy Baby

Housing Safety/Stability Parental Discord Parenting Skills Prenatal

Relationship Concerns Other:

Referring Agency:

Agency Contact: Email:

Address: Phone:

Referral Representative Signature and Date HFC Staff Signature and Date

Reason for Referral: ____

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