

Internal Use Only

Received by: _____

Date received: _____

Date contacted referral source: _____

Date contacted family: _____



Intensive Family Preservation Referring Agency Referral Form – DSS

Region 7 includes: Anson, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Richmond, and Scotland

This form may be signed by the referring Social Worker's Supervisor and sent to the IFPS program to begin a referral. The Supervisor's signature verifies that all information below is correct and the family does in fact meet the criteria for provision of IFPS services as outlined in the State's IFPS Policies & Procedures. Please accompany this form with all supporting documents at time of referral.

Referring Agency: _____	County DSS
Referring Worker: _____	Phone: _____
Supervisor Name: _____	Phone: _____
Supervisor Signature: _____	Date: _____

Client Information:	Family Name: _____	Phone: _____
Address: _____		
Parent/Caretaker(s):	attach additional sheets if there are more caregivers/children	
1. Name: _____	Relationship to child: _____	Age: _____
2. Name: _____	Relationship to child: _____	Age: _____
Child(ren):		
1. Name: _____	SIS number: 200 _____	
DOB: _____	Primary maltreatment type found: (field 31 on 5104) _____	
2. Name: _____	SIS number: 200 _____	
DOB: _____	Primary maltreatment type found: (field 31 on 5104) _____	
3. Name: _____	SIS number: 200 _____	
DOB: _____	Primary maltreatment type found: (field 31 on 5104) _____	
4. Name: _____	SIS number: 200 _____	
DOB: _____	Primary maltreatment type found: (field 31 on 5104) _____	
5. Name: _____	SIS number: 200 _____	
DOB: _____	Primary maltreatment type found: (field 31 on 5104) _____	

DSS Referrals: Type found was which of the following:
<input type="checkbox"/> substantiation of abuse, neglect or dependency AND a rating of high or intensive on the Risk Assessment
<input type="checkbox"/> finding of services needed AND a rating of high or intensive on the Risk Assessment (family assessment cases)
<input type="checkbox"/> substantiation of abuse AND a rating of high or intensive on the Risk Assessment
DSS Risk Rating: <input type="checkbox"/> Intensive <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low Date of Substantiation/Svcs Needed: _____
<u>Note: If Substantiation occurred, maltreatment information in previous section <i>must be completed</i>.</u>
<u>Check all forms that are attached.</u> (Note: Below forms required at time of referral, please contact IFPS staff if concerns exist)
<input type="checkbox"/> DSS 5027 <input type="checkbox"/> Family Risk Assessment or Reassessment (5230 or 5226) <input type="checkbox"/> NC Safety Assessment (5231)
<input type="checkbox"/> Family Strengths and Needs (5229) <input type="checkbox"/> Case Decision Summary/Initial Case Plan (5228)

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IFPS Agency: Date/Time Received: _____ Staff Assigned: _____

Action Taken: _____

**Please fax this form to (910) 202-5772, Attention: Josh Main, IFPS Supervisor. Please label fax as URGENT
OR email this form to jmain@coastalhorizons.org- Subject: Intensive Family Preservation Referral.**

**After Hours or Weekend Referrals should be faxed but accompanied with a phone call with either.
We are ALWAYS willing to staff in questions by calling the below numbers!**

Ryan Estes, IFPS Program Director 336-926-2896

Or

Josh Main, IFPS Supervisor 910-524-6630