

**Internal Use Only**

Received by: \_\_\_\_\_

Date received: \_\_\_\_\_

Date contacted referral source: \_\_\_\_\_

Date contacted family: \_\_\_\_\_



**Intensive Family Preservation Referring Agency Referral Form – DSS**

Region 9 includes: Bladen, Brunswick, Columbus, Duplin, New Hanover, Pender, Robeson, Sampson

*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.*

<b>Referring Agency:</b> _____	County DSS
Referring Worker: _____	Phone: _____
Supervisor Name: _____	Phone: _____
Supervisor Signature: _____	Date: _____

<b>Client Information:</b>	Family Name: _____	Phone: _____
Address: _____		
<b>Parent/Caretaker(s):</b>	attach additional sheets if there are more caregivers/children	
1. Name: _____	Relationship to child: _____	Age: _____
2. Name: _____	Relationship to child: _____	Age: _____
<b>Child(ren):</b>		
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) _____	

<b>DSS Referrals:</b> Type found was which of the following:
<input type="checkbox"/> substantiation of abuse, neglect or dependency <b>AND</b> a rating of high or intensive on the Risk Assessment
<input type="checkbox"/> finding of services needed <b>AND</b> a rating of high or intensive on the Risk Assessment (family assessment cases)
<input type="checkbox"/> substantiation of <b>abuse AND</b> 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</i> be completed.</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)

**Internal Use Only**

Received by: \_\_\_\_\_

Date received: \_\_\_\_\_

Date contacted referral source: \_\_\_\_\_

Date contacted family: \_\_\_\_\_

**IFPS Agency:** Date/Time Received: \_\_\_\_\_ Staff Assigned: \_\_\_\_\_

Action Taken: \_\_\_\_\_

**Please fax this form to (910) 202-5772, Attention: Lisa Burriss, IFPS Supervisor. Please label fax as URGENT  
OR email this form to [lburriss@coastalhorizons.org](mailto:lburriss@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**

**Lisa Burriss, IFPS Supervisor 910-515-0493**