REFERRAL FOR SERVICES FOR FFA OR GROUP HOME CLIENT

(To avoid delay of services, complete ALL form sections)

Date: _____ Client Name: _____

Client DOB: _____ Client SSN: _____

Date of Placement: _____ Client Medi-Cal #: _____

Name of Client's Siblings: _____

_____

_____

Name of Group Home or FFA: _____

Address of FFA: _____

Client's Residence Address & Phone Number: _____

_____

County Social Worker Name: _____ County SW Phone #: _____

Foster Parent's Name: _____

School Client is Attending: _____ Grade: _____

Desired Service: ☐ Therapy Service ☐ Psychiatric Services

Urgent Due to: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Out of Medication

List Current Medications: _____

_____

Rationale for Change of Provider/Requested Services **(must include symptoms and how symptoms impair consumer functioning)**:

_____

_____

_____

_____

_____

Developmental Delay? ☐ Yes ☐ No Regional Center Client? ☐ Yes ☐ No

Desired Provider (must specify): _____

Signature of Requestor: _____

Requestor's Printed Name and Title: _____

Relationship to client: _____

Requestor's Phone Number: _____

Requestor's Fax Number: _____

Fax to Community Access, Referral, Evaluation, & Support (C.A.R.E.S.) (951) 358-5352

Confidential Patient Information. See California Welfare & Institutions Code Section 5328

This is an official form – Do NOT Alter