|  |  |  |
| --- | --- | --- |
| **Date:** | **Case #:** | **YCOCYF Intake Date:** |

|  |  |
| --- | --- |
| **CYF Unit** | **Type of Case/Referral** |
| Intake  Family Preservation  Reunification/Permanency | Child Abuse  Child Neglect  Caregiver Substance Abuse  Housing  Domestic Violence  Child/Youth Mental Health/Behavioral Concerns  Caregiver Mental Health/Behavioral Concerns  Lockout  Truancy  Parental Conflict  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | |
| Referring Agency: | Name: |
|  | |
| CYF Caseworker | Name: |
| Phone: | Email: |
|  | |
| CYF Supervisor | Name: |
| Phone: | Email: |
|  | |
| CYF Division Manager | Name: |
| Phone: | Email: |

|  |
| --- |
| **Is an Emergency Meeting needed?**  Yes No *Specify before date*: **Click here to enter a date.**  *(Meetings are held M, W, Th at 9,11, and 1 (3pm for emergencies). Emergency meetings can also be held on Friday at anytime)*  **Has there been a referral to one of the following?** FGDM FTM CASSP JPT  **Has dependency been filed?** Yes No **Is the child currently in placement?** Yes No  **School District and Name of School:** |

***SECTION II* CONTACT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Caregiver** | **Relationship** | **Address** | **Phone** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**HOUSEHOLD DEMOGRAPHICS**

*(Include name and age of all children in the home)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** | **DOB** | **Race** | **Hispanic (Y/N)** | **Gender Identity** (Male, Female, Trans, Other) | **Sexual Orientation**  (Gay, Straight, Bisexual, Other, Unsure/Unknown) | **MA ID Number** | |
| ***Client child:*** |  |  |  |  |  |  | |
| *Caregiver 1: see above* |  |  |  |  |  |  |
| *Caregiver 2:* |  |  |  |  |  |  | |
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***SECTION III***

|  |
| --- |
| **Summary of Needs and Meeting Goals (*Please provide as much information as possible*):** |

***SECTION IV* F a m i l y B a c k g r o u n d**

|  |  |
| --- | --- |
| **PLEASE PROVIDE NAME OF ENTITY PROVIDING SERVICES (Present and Past). INCLUDE ADDRESSES, PHONE #S, EMAIL, INDIVIDUAL(S) PROVIDING SERVICE, DATES OF SERVICE, INTERVENTIONS, OUTCOMES IF COMPLETED, AND ANY OTHER DETAILS AVAILABLE AT TIME OF REFERRAL.** | |
| Prior OCYF History: |  |
| Placement History: |  |
| Criminal/DJJ History:  ***Felony Convictions*** |  |
| Medical Concerns (Physical Health) |  |
| Mental Health/Behavioral: |  |
| Substance Abuse History: |  |
| Sexual Abuse History: |  |
| Domestic Violence History: |  |
| Education: *(guidance counselor, IEP, etc.*) |  |
| Housing Needs:  ***Evictions*** |  |
| **Religious Affiliation/Church** |  |
|  |  |
| **Family/Caregiver Income Range** | Unemployed  Unknown  $0-15,000  $15,000-24,999  $25,000-49,999  $50,000-74,999  Over 74,999 |

**Please provide your availability:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Day** | **Date** | **Time available** | **Comments** |
| **Monday** |  |  |  |
| **Wednesday** |  |  |  |
| **Thursday** |  |  |  |
| **Friday (Emergency only)** |  |  |  |