|  |  |  |
| --- | --- | --- |
| **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)** |  |  |  |