INTENSIVE IN HOME SERVICES
Referral to Integrated Family Services, PLLC

Referral Date: __________ **Name of Referral Source/Contact Information:** __________________________

First: _______________________ **Middle:** ______________________ **Last:** ___________________________

Sex (circle) M F **Date of Birth**: ________________ **SS#:** _____________________

Street Address: ______________________________ **Town/City**: ______________ **Zip**: _______________
Mailing Address (if different): _______________________ **Town/City**: ______________ **Zip:** _______________
Home Phone: ________________ **Cell:** ______________ **Work #:** ______________ **Email:** ____________________

Race (please circle) **Black** **White** **American Indian** **Alaskan Native** **Asian/Pacific Islander** **Biracial**
Ethnicity (please circle) **Not Hispanic Origin** **Hispanic, Mexican American** **Hispanic, Cuban** **Hispanic, Puerto Rican** **Hispanic, Other**
Do You Speak English? Y N **Do You Understand English? Y N**
Current Medications Prescribed: ____

Mother's Name: _______________________________ **Father's Name:** ______________________________________
Guardian if Not Parent: ________________________**(relationship)**____
Does Guardian have legal custody? Y N
Emergency Contact: ____

EDUCATION
School Attending: ____**Grade:**______________________________
If not enrolled in school, what is the highest grade completed? ____________________________________

INSURANCE (Intensive In Home Services can only be provided to Medicaid Recipients and those with no insurance)

Type of Insurance: **Medicaid Y N** **Co-Pay:** __________ **Copy of Card Attached: Y N**
Private Y N **Co-Pay:** __________ **Copy of Card Attached: Y N**
Name of Insurance Provider:____
No Insurance: Y N

REASON FOR REFERRAL **Use space on back for additional information**
Referring behaviors that make client at risk of being placed out of the home:
____
____
____
____
____

Legal Involvement:
____

Current Living Situation: (Home, Group Home, Therapeutic Foster Care, etc)
____

COMPLETED BY IIH TEAM LEADER
Screened By: __________________________________

Assessment scheduled for Date/time: ________________________ **Therapist:** ___________________________