

**Healthy Families Project  
Parent Partner Referral Form**

**Phone: 402-441-3805  
Fax: 402-477-2198**

Parent's Name 1 \_\_\_\_\_ Identified Youth's Name \_\_\_\_\_  
Parent's Name 2 \_\_\_\_\_ Youth Age or Birth Date \_\_\_\_\_ M \_\_\_ F \_\_\_  
Parent's Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ County \_\_\_\_\_  
Parent Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Number of adults in family \_\_\_\_\_ Number of children in family \_\_\_\_\_

Contact the: Care Coordinator Family Directly Case Worker

Care Coordinator-Case Worker \_\_\_\_\_ Telephone \_\_\_\_\_  
Supervisor Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Next Team Meeting Date \_\_\_\_\_ Place \_\_\_\_\_  
Identified Youth Race \_\_\_\_\_ Identified Family Race \_\_\_\_\_  
Youth Serious Emotional Disorders \_\_\_\_\_  
Substance Abuse Issues \_\_\_\_\_  
School Issues \_\_\_\_\_  
Behavior Issues \_\_\_\_\_  
State Ward Yes No  
Youth Involved with Protection & Safety Yes No  
Youth at Home Yes No  
Youth in Placement Yes No Name of Placement \_\_\_\_\_  
Safety Plan in Place Yes

Family Goals—Assistance Requested

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Child Protective Services Only)

Master Case Name \_\_\_\_\_ Master Case Number \_\_\_\_\_

(Office Use Only)

Date Received \_\_\_\_\_  
Date Assigned to Parent Partner \_\_\_\_\_  
Parent Partner \_\_\_\_\_  
Assigned Program:

- ICCU
- Community-Based
- State Mentoring
- Family Drug Court
- FYI
- Parent Ed. Class
- Cedars
- Other \_\_\_\_\_

**Referral Source**

- Case worker referral
- Family self-referral
- Region V referral-FYI
- Community-Based Wraparound referral
- Agency referral \_\_\_\_\_
- Family Resource Center referral
- Caseworker ICCU referral
- Family Drug Court
- Other