FaCT Family Resource Center Referral Form for Family Support Services

Please FAX this Form to the FRC selected for services

Referring Person/Worker Name:	Agency/Department:	Email:
Worker Phone:	Fax:	Date:

Referring to: *(Please mark site below)* *This is a CalWorks Family Stabilization (**FS**) Referral* *This is a Differential Response (**DR**) referral*

	Anaheim Harbor FRC Anaheim F (714) 399-0595 T (714) 399-0590		**CHEC FRC** San Juan Capistrano F (949) 489-7748 T (949) 489-7742		**Corbin FRC** Santa Ana F (714) 543-4947 T (714) 480-3737		**Costa Mesa FRC** Newport Beach F (949) 764-4543 T (949) 764-8100
	El Modena FRC Orange F (714) 532-3593 T (714) 532-3595		**Family Oasis FRC** Anaheim F (714) 956-1990 T (714) 517-7107		**Friendly Center-Orange FRC** Orange F (714) 771-7627 T (714) 771-5300 DR F (714) 455-3661 DR		**Friendly Center-Placentia FRC** Placentia F (714) 632-3851 T (714) 769-8660
	La Habra FRC La Habra F (714) 447-3753 T (714) 447-3460 FS DR		**Magnolia Park FRC** Garden Grove F (714) 530-7908 T (714) 530-7413		**Minnie Street FRC** Santa Ana F (714) 972-5781 T (714) 972-5775 FS DR		**Oak View FRC** Huntington Beach F (714) 842-4184 T (714) 842-4002 FS DR
	South Orange County FRC Lake Forest F (949) 364-0575 T (949) 364-0500 FS DR		**Stanton FRC** Stanton F (714) 379-0139 T (714) 379-0129		**Westminster FRC** Westminster F (714) 903-1881 T (714) 903-1331		

Clients to Be Served:

Parent/Caregiver Name:				D.O.B:
Address:	City:	State:	Zip:	Phone:

Other Family Members to Be Served:

Name:				
D.O.B:				
Relationship:				

CIN # (12 Digits):	CalWORKS Case # (7 Digits):	CFS Referral # (19 Digits):

CWS Service Component: ☐ Court ☐ Non-Court | CalWorks Worker Name: | Phone:

☐ Emergency Response ☐ Family Maintenance ☐ Family Reunification ☐ Permanent Placement (Specify):_______________

☐ Information About Classes, Programs, and Resources	☐ Individual Case Management	☐ Health Services
☐ In-home Parenting (0-5)/Family Support	☐ Parenting Classes	☐ Mother/Infant Bonding/Breastfeeding
☐ Domestic Violence Intervention Services	☐ Family Activities	☐ New Mom/Dad
☐ Adult English as a Second Language (ESL)	☐ After-School Programs	☐ Teen Mom/Dad
☐ Emergency Assistance	☐ Teen/Youth Programs	☐ Public Health Nurse
☐ Housing	☐ LGBTQ	☐ Other: _______________
☐ Counseling	☐ Health Insurance Assistance	☐ DR Only: Client Declined Initial Referral*

Does this case need a bilingual worker? ☐ No ☐ Yes *If Yes, please specify language:*_______________

Does the FRC staff need to talk with the referring party prior to intake? ☐ No ☐ Yes

**FRC DR staff to follow up with second/third attempt.* Phone Call Mailed Info

Reasons for Referral/Additional Information: ***Please list any "red flags" that may be present***

Service Agreement and Authorization to Release Information:

The referring party has explained to me the purpose for this referral. I agree to be contacted by FRC staff and have a copy of this referral faxed or to take a copy of this referral to the Family Resource Center. I agree to attend any scheduled appointments with the Family Resource Center.

I authorize the release of information between _______________(referring agency) and _______________ (above indicated Family Resource Center) for the period this service agreement remains in effect. This information will pertain to the reasons for referral and presenting problem and will be used for consultation, evaluation, assessment, and treatment of the client(s) to be served. Information may also be released to the Orange County Social Services Agency for program evaluation and/or State-required reports. *This referral was explained to me in my native language.*

_______________ Client Signature Date

_______________ Referring Person Signature Date

Assigned FRC Staff/Program: