



DFACS REFERRAL FORM
PROJECT PATHFINDER

Please PRINT clearly using dark ink.

Date: Assessment needed? Yes No

Open case at DFCS? Yes No Status:

(CIRCLE ONE)

Investigator/Ongoing Caseworker: Phone:

Is child currently in foster care? Yes No

Parent/Guardian: Home Phone:

Parent/Guardian's Relationship to Child: Work Phone:

Complete Address:

County of Residence: Parent/Guardian SSN:

Name(s) of Child(ren) being Referred for Treatment:

Sex: Age: Date of Birth:

Sex: Age: Date of Birth:

Child's Ethnic Origin: Caucasian African American Hispanic Asian Other

Does family/child have Medicaid? Yes No Don't Know

Victim(s) Name/Age/Ethnic Origin & Relationship to Child/Adolescent:

Any charges? Yes No If yes, indicate charge/s:

Juvenile Court Involved? Yes No

Is there a probation officer? Yes No Name:

Summary of Allegations:

Gross Family Income:

Less than \$10,000
Less than \$10,000
\$20,000 - \$29,999
\$30,000 - \$39,999
\$40,000 & over
Unknown

Income Sources:

Full-Time Employed
Full-Time Employed
TANF
Child Support
SSI
Unknown

Head of Household

Highest Level of Education:

9-12 grades Bachelor Degree
HS or GED Post Grad
Tech School Other
Some College Unknown

Is the family aware a referral has been made to CCHH/Pathfinder? Yes No