Strengthening Families
REFERRAL FORM

Date of Referral:			
Referring agency/Contact person:			**Phone #:**
Family Name:			
Address:	**City:**	**State:**	**Zip:**
Phone #:	**Message Phone #:**		

Family Information: *(All adults and children in the home)*

Name *(First and Last)*	**Age**	**Date of Birth**	**Relationship** *(mother, father, son, daughter, foster parent, other caregiver)*

Please list all programs in which the family is currently involved (or has completed):

Does this family have an open CWS case? ☐ Yes ☐ No *(If yes, please answer the following questions)*

Social Worker Name:	**Phone #:**
County:	

Is anyone on probation/parole? ☐ Yes ☐ No *(If yes, please answer the following questions)*

Probation/Parole Officer Name:	**Phone #:**
County:	

Will transportation be needed? ☐ Yes ☐ No

Does family require childcare for participating in the Strengthening Families Program? ☐ Yes ☐ No

Is this family ☐ volunteering or ☐ court ordered, to this program? *(Please indicate)*

Any additional information for this family?

Please fax or drop off completed referral form to:
Glenn County Behavioral Health: c/o Francis P. Cuny
1187 East South Street
Orland, CA 95963
PHONE: (530) 865-1146 FAX: (530) 865-6483
Thank you!

Glenn County Behavioral Health Strengthening Families Program REFERRAL FORM	**Client Name:** **Client ID:**

CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)