Reunification Referring Agency Referral Form

This form may be signed by the referring Social Worker's Supervisor and sent to the Reunification program to begin a referral. The Supervisor's signature verifies that all information below is correct and the family does in fact meet the criteria for provision of Reunification services as outlined in the State's Reunification Policies & Procedures. Although this form is sufficient to begin a referral, the Reunification worker will need actual copies of some forms soon after starting work with the family.

Referring Agency:

Note that referrals may only come from county Departments of Social Services

Referring Worker: _____ Phone: _____

Supervisor Name: _____ Phone: _____

Supervisor Signature: _____ Date: _____

Client Information:

Family Name: _____ Phone: _____

Address: _____

Parent/Caretaker(s): attach additional sheets if there are more caregivers/children

1. Name: _____ Relationship to child: _____ Age:_____

2. Name: _____ Relationship to child: _____ Age:_____

Child(ren):

1. Name: _____ DOB: _____ SIS:_____

   Is *this* child in custody of DSS? ☐Yes ☐No (*At least one child must be in DSS custody for the family to be eligible for services)*

   If yes, date removed from home: _____ Maltreatment code for incident leading to removal: ____

2. Name: _____ DOB: _____ SIS:_____

   Is *this* child in custody of DSS? ☐Yes ☐No (*At least one child must be in DSS custody for the family to be eligible for services)*

   If yes, date removed from home: _____ Maltreatment code for incident leading to removal: ____

3. Name: _____ DOB: _____ SIS:_____

   Is *this* child in custody of DSS? ☐Yes ☐No (*At least one child must be in DSS custody for the family to be eligible for services)*

   If yes, date removed from home: _____ Maltreatment code for incident leading to removal: ____

4. Name: _____ DOB: _____ SIS:_____

   Is *this* child in custody of DSS? ☐Yes ☐No (*At least one child must be in DSS custody for the family to be eligible for services)*

   If yes, date removed from home: _____ Maltreatment code for incident leading to removal: ____

5. Name: _____ DOB: _____ SIS:_____

   Is *this* child in custody of DSS? ☐Yes ☐No (*At least one child must be in DSS custody for the family to be eligible for services)*

   If yes, date removed from home: _____ Maltreatment code for incident leading to removal: ____

Check all forms that are attached. (Note: If forms not attached, please forward to Reunification worker asap)

☐DSS 5027 ☐Family Risk Assessment or Reassessment (5230 or 5226) ☐NC Safety Assessment (5231)

☐Family Strengths and Needs (5229) ☐Family Services Case Plan ☐Court Order Verifying Custody

Reunification Agency: Date/Time Received: _____ Staff Assigned: _____

Action Taken: _____