



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)		<i>This is a CalWorks Family Stabilization (FS) Referral</i>		<i>This is a Differential Response (DR) referral</i>	
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	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 (949) 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): _____

<input type="checkbox"/> Information About Classes, Programs, and Resources	<input type="checkbox"/> Individual Case Management	<input type="checkbox"/> Health Services
<input type="checkbox"/> In-home Parenting (0-5)/Family Support	<input type="checkbox"/> Parenting Classes	<input type="checkbox"/> Mother/Infant Bonding/Breastfeeding
<input type="checkbox"/> Domestic Violence Intervention Services	<input type="checkbox"/> Family Activities	<input type="checkbox"/> New Mom/Dad
<input type="checkbox"/> Adult English as a Second Language (ESL)	<input type="checkbox"/> After-School Programs	<input type="checkbox"/> Teen Mom/Dad
<input type="checkbox"/> Emergency Assistance	<input type="checkbox"/> Teen/Youth Programs	<input type="checkbox"/> Public Health Nurse
<input type="checkbox"/> Housing	<input type="checkbox"/> LGBTQ	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Counseling	<input type="checkbox"/> Health Insurance Assistance	<input type="checkbox"/> 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 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.

This referral was explained to me in my native language.

Client Signature Date

Referring Person Signature Date