PASS (Parents Acquiring Skills and Strength) – Parenting Class Referral

1. Please complete this form with the parent/guardian and fax to: Referral Intake Coordinator, c/o Home of the Innocents, Fax# 596-1400.
2. If you have questions about the PASS program or a particular referral, please call 596-1303.
3. PLEASE DO NOT LEAVE ANY BLANKS – if something does not apply, indicate with "n/a".

Any information obtained through this referral is confidential and is intended for use by Home of the Innocents to provide the necessary services for the stated client(s) and his/her family in accordance with all local, state, federal, and other regulatory requirements.

Type of referral (check only one):

☐ **Level 1** (**LOW RISK:** no previous court history, no history of domestic violence, No current or prior CPS involvement, minimal family issues)

☐ **Level 2** (**MODERATE RISK:** active/prior history in family court, no juvenile court History, no CPS involvement within last 3 years, no history of family Violence)

☐ **Level 3** (**HIGH RISK:** previous family and/or juvenile court history, current/prior CPS involvement, multiple family issues)

Date of Referral:____/____/____

Information about the Parent(s):

Parent's (or petitioner's, if applicable) full name: _____

Parent's Date of Birth _____ Parent's Social Security Number _____

Parent's address (including city, state, zip code and county):

_____

_____

Parent's phone number and best time to call: _____

Are there family members including yourself with a history of mental health problems or substance abuse? ☐ Yes ☐ No

If "yes", please explain: _____

_____

Do any family members have current or past cases pending in the court system (including family court and criminal court)?

☐ Yes ☐ No

If "yes", please explain _____

_____

Does your family have a "worker" from Child Protective Services (CPS), Family Court, or other agency? ☐ Yes ☐ No

If "yes", please provide worker's name and phone number: _____

Is there a case in Family Court? ☐ Yes ☐ No

If "yes" please fill out the following section. If "no" move to the next section.

Family Court Division: _____ Family Court Case Number: _____

Child Currently Lives With:_____ Relationship:_____

Is this person the legal guardian? ☐ Yes ☐ No

If "no", please list guardian's name and phone number: _____

Address Where Child Currently Lives:_____

Phone Number/Best Time To Call Where Child Currently Lives:_____

Name & Title of Person Making Referral:_____

Phone Number of Person Making Referral:_____

Why is this family being referred? Please describe the presenting problems in detail: _____

_____

_____

_____

_____

_____

_____

_____

_____

Information about the Child(ren):

Name	DOB	Sex	Race	Social Security Number
1.				
2.				
3.				
4.				

Has the child/children received counseling for mental health/behavioral problems or substance abuse? ☐ Yes ☐ No

If "yes", please describe, list where and when: _____

_____

Has the child/children ever been hospitalized for mental health problems? ☐ Yes ☐ No

If "yes", please describe, list where and when: _____

Will any children be attending class with the parent? ☐ Yes ☐ No

If yes, please provide names and ages: _____

_____

_____

Who lives in the home with the parent?

Household Members (please include information for ALL household members, including parents, siblings, etc.):

	Name	Relationship	Age	Sex	Race
1.					
2.					
3.					
4.					
5.					
6.					

● PARENT/GUARDIAN: PLEASE READ, UNDERSTAND AND SIGN BELOW●

I understand that this is a referral for services and does not guarantee acceptance into the program. If my family is accepted, I agree to fill out to all evaluations and assessments pertaining to the program, where basic family information will be gathered and an initial service plan will be developed. By signing below I authorize the Intake Coordinator to share information from this referral and the initial assessment with the PASS team, Home of the Innocents, Louisville Metro Government/Department for Human Services, Jefferson County Attorney's Office, Jefferson County District Public Defender, Cabinet for Families & Children, Child Protective Services for the purposes of providing treatment services to my family and ongoing monitoring of the PASS program.

Signature of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

CASE MANAGER USE ONLY

Date Received: _____

CONTACTS

1st Attempt:

_____

2nd Attempt:

_____

3rd Attempt: