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| Date of Referral:  |
| **Family Referred for Services** |
| Parent(s):  |
| Primary Phone:  | Secondary Phone:  |
| Primary Email:  | Secondary Email:  |
| Physical Address: County: | Mailing Address:  |
| Marital Status:  | Parent(s) Race:  |
| **Child’s Name**  | **DOB & Gender Identity** (i.e., Male, Female, Transgender, Non-Binary) | **Relationship** (i.e., Adopted Child, Foster Child, Biological Child) | **Race/Ethnicity** |
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| **Referral Information For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Check one:** [ ]  **The family referred has a legal, finalized adoption**Actual or approximate date of finalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Type of Adoption** [ ]   **Foster Care** [ ]   **Domestic** [ ]   **International** |
| **Reason for Referral & Current Services** Please provide a brief description of why you are referring the family to post adoption services and current needs of the family (i.e.: training/education, peer support, family events, behavior challenges, birth family connection): Please list any current services accessed by the family:  |
| **If other than self-referral, please provide the following information:** * I have explained Post Adoption Services to this family and the family knows to anticipate follow-up from a worker who will enroll them in services.

Worker: Phone: \_\_\_\_\_\_\_\_E-mail: \_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Please send all referrals to Shannon Shepherd- Fax: 276.623.0002** **Email:** **SShepherd@depaulcr.org** |

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| **Staff Use Only** **Check one:**[ ]  Piedmont Region ReferralDate Assigned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Assigned Case Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Western Region ReferralDate Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_Assigned Case worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

