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| --- | --- | --- | --- |
| *Office Use* | *Date Received:* | *Date Assigned:* | *Date 1st Contact:* |

|  |  |
| --- | --- |
| **Referring Agency Information** | |
| Agency Name: | Today’s Date: |
| Referring Person’s Name: | Title: |
| Email: | Phone: |
| Supervisor’s Name: | Title: |

|  |  |  |  |
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| **Family Information** | | | |
| 1st Parent’s Name: | | | Date of Birth: |
| Address: | | | Apt. #: |
| City, State: | | | Zipcode: |
| Phone(s) Home: | Work: | | Mobile: |
| 2nd Parent’s Name: | | | Date of Birth: |
| Address: | | | Apt. #: |
| City, State: | | | Zipcode: |
| Phone(s): Home: | Work: | | Mobile: |
| Primary language?  English  Spanish  Spanish only  Other: | | Can adult read? Yes  No  Can adult write? Yes  No | |
| Transportation?  Yes  No | | On bus line?  Yes  No | |

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| **Children’s Information** | | | | |
| Child’s Name or Initials | Sex | Ethnicity | Age | Who is child living with? |
| 1. Primary Child: |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

|  |  |
| --- | --- |
| **Services** | |
| Check the Nurturing Program services being requested. | |
| Therapeutic Parent Coaching | Direct Youth Services |
| Fatherhood Services | Assessment Services |
| Trauma-Based Counseling/Therapy | Other (specify) |
| **Additional Services Information** | |
| Substance Abuse Concerns?  Yes  No | Mental Health Concerns:  Yes  No  Diagnosis: |
| Family’s first time in services? Yes  No  If no, time in services: | |
| Has family received Nurturing Program Services? Yes  No | |
| Is this service court ordered?  Yes  No | |

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| Check the assessments that have been completed: | |
| Adult Adolescent Parenting Inventory (AAPI) | Children Social/Emotional Ages & Stages |
| Family Strength Needs Assessment (FSNA) | Adverse Childhood Experiences (ACE) |
| Other |  |

|  |
| --- |
| If Child has been removed, share reason for removal and/or DFPS involvement: |
| Home Safety Information for Parent Coach/Therapist: |
| **I (Parent Name) give permission for   (Referring Person & Agency) to give the following contact information to The Family Nurturing Center of Texas staff as part of a referral process.  I agree for my contact information to only be utilized for referral purposes and only to be released to staff working under the Family Nurturing Center of Texas providing Therapeutic Parent/Youth Coaching, Trauma-based Therapy and/or Parent Assessment Services.**  **1st Parent/Guardian Signature: Date:**  **2nd Parent/Guardian Signature: Date:**  **Youth over 12 years of Age Signature: Date:**  \* Both parent/guardian signatures required if two individuals are parenting the primary referred child.  \* Youth and parent signatures required if Youth over 12 years of age is participating in direct services. |