



**GENESIS II FOR FAMILIES  
PROGRAM REFERRAL FORM**  
Fax: 612.617.0193

Date of Referral \_\_\_\_\_

**CLIENT INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
County \_\_\_\_\_  
Phone \_\_\_\_\_

Birthdate (Age) \_\_\_\_\_  
Gender \_\_\_\_\_  
Ethnicity \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Phone \_\_\_\_\_

**REFERRING PARTY**

Name \_\_\_\_\_  
Agency \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_

**Medical Assistance / GAMC #**  
\_\_\_\_\_  
**Health Insurance and ID #**  
\_\_\_\_\_  
**Social Security Number (SSN) #**  
\_\_\_\_\_  
*Please indicate if the Client does not have insurance.*

**SERVICES REQUESTED (check as many as apply)**

**Adult Parent Education:**  
\_\_\_\_\_ Family Focus Day      \_\_\_\_\_ Family Focus Evening      \_\_\_\_\_ In-Home Parenting

**Behavioral Health Services:**  
\_\_\_\_\_ Therapy Services      \_\_\_\_\_ Psychological Evaluation  
\_\_\_\_\_ Parenting Assessment      \_\_\_\_\_ Parent-Child Interaction Therapy (PCIT)

**Next Phase Youth Services:**  
\_\_\_\_\_ Teen Parenting Program      \_\_\_\_\_ Independent Living Skills  
\_\_\_\_\_ Bright Beginnings

**Supervised Parenting**  
\_\_\_\_\_ Center-based      \_\_\_\_\_ In-Home  
\_\_\_\_\_ Monitored Visits      \_\_\_\_\_ Safety Exchange

**REASON FOR REFERRAL**

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**CHILD INFORMATION**

**Child                      DOB                      Sex                      Ethnicity                      Placement (ex. foster care.)**

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**MEDICAL**

- Mental Health Diagnosis \_\_\_\_\_
- Medications \_\_\_\_\_
- Chemical Dependency Issues \_\_\_\_\_

**FINANCIAL SUPPORT (check as many as apply)**

- Receiving MFIP    \$ \_\_\_\_\_                       Receiving SSI    \$ \_\_\_\_\_
- Receiving GA    \$ \_\_\_\_\_                       Income                      \$ \_\_\_\_\_

**LEGAL / LIVING SITUATION (check as many as apply)**

- On probation                       Child Protection case open                       Out of home placement  
(i.e. –foster care)
- On parole                       Halfway house
- In jail                       Residential treatment                       Independent
- In workhouse                       Transitional housing                       Other living arrangement –  
\_\_\_\_\_

**INVOLVEMENT WITH COUNTY SYSTEMS & OTHER AGENCIES (check as many as apply)**

- Criminal Justice                       Family Court
- Child protection                       Assistance program through state
- Chemical Dependency Program \_\_\_\_\_
- Other \_\_\_\_\_

**CONTACTS (Complete all that apply):**

Child Protection Worker \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Probation Officer \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

MFIP Worker \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Case Manager / Social Worker \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Individual Therapist \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Other \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**COLLATERAL INFORMATION (please check if attached)**

- Parenting Assessment
- Child Protection Case Plan
- Psychological Evaluation
- Pre-Sentence Investigation
- Court Hearing Report
- Other \_\_\_\_\_

**Please attach a copy of the Release of Information signed  
by the Client to the referral when applicable.  
Thanks.**