THE CENTER FOR CHILDREN & FAMILIES

info@standforhope.org / www.standforhope.org

REQUEST SERVICES

Date Received : /

Date of Referral:	Client Age: ☐ 0-21 ☐ 21+	Relationship to Child:

CLIENT INFORMATION

Client Name :	Date of Birth : / ☐ M ☐ F
SS# :	☐ Medicaid ☐ Self-Pay ☐
Parent/Guardian Name :	Insurance Policy Number :
Email :	Insurance Member ID :
Phone Number : /	Name of Insured :
Address :	Date of Birth of Insured :
	Preferred Language :

COUNSELING REASON:

☐ Separation, Divorce, or Blended Family ☐

☐ Abuse/Neglect	☐ Depression	☐ Inadequate Shelter	☐ Medication Management	☐ School Issues
☐ Anxiety	☐ Family Issues	☐ Lack of Supervision	☐ Mental Health Concerns	☐ Self-harm
☐ Behavior Issues	☐ Grief (Loss)	☐ Legal Issues	☐ Trouble Adjusting	☐ Substance Use
☐ Community Issues	☐ IEP	☐ Medical Issues	☐ Difficulty Communicating	☐ Suicidal
☐ Relationship Conflict	☐ Stress	☐ Impacts of Trauma	☐ Post-partum Depression	☐ Parenting Help

PREVIOUS/CURRENT SERVICES:

☐ CAC	☐ CPS	☐ DCFs	☐ Counseling	☐ DYS/Probation	☐ Brokers of Hope	☐ Other
☐ CASA	☐ CSoC	☐ FINS	☐ Wraparound Services	☐ OJJ/Probation	☐ Medication Management	☐ None

SERVICES REQUESTED:

☐ Any Eligible	☐ FFT	☐ Brokers of Hope	☐ Crisis Intervention	☐ Community Support Services
☐ Counseling	☐ FFT-CW	☐ Peer Support	☐ Medication Management	☐ Juvenile Drug Court Treatment
	☐ FSYT	☐ Play Therapy	☐ Outpatient Counseling	☐ Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
	☐ ART	☐ EMDR	☐ Mental Health Counseling	☐ Mental Health Assessment

REFERENT INFORMATION

Referent Name :	Agency :
Referent Phone :	Referent Supervisor :
Referent Email :	Supervisor Phone :
Referent Address :	Supervisor Email :
	Preferred Therapist :
How Did You Hear About Us?	Preferred Modality :