The Center for Family Success
Referral Form

Date of referral: _____

Client's Full Name: _____ Client's Date of Birth _____

Client's Phone Number: _____ Client's Email: _____

Client's Gender Identity: _____ Client's SID #: (if applicable) _____

Client's Current Address: _____

Is this client on supervision to Multnomah County Department of Community Justice (DCJ)? ☐ Yes ☐ No

List specific (DCJ) unit/program here (i.e. MCJRP, FSAP, DV unit): _____

Does the client have an open DHS - Child Welfare case? ☐ Yes ☐ No

DHS Case number(s): _____ **DHS Participant number:** _____

☐ The individual being referred has restrictions specific to being in the presence of children.
All restrictions will need to be staffed with a Center staff before an Intake may be scheduled due to the presence of children on the agency premises.

Name(s) and Age(s) of child(ren): _____

Is client allowed to have contact with their *own* children? ☐ Yes ☐ No

☐ **My office/unit has a valid release of information** that allows me to discuss their case with the Center for Family Success.
Please attach a copy of this signed release with this completed referral form.

Referred by: ☐ Self ☐ Parole/Probation ☐ DHS Child Welfare ☐ Not listed: _____

Name of referrer: _____ Agency Affiliation: _____

Phone Number: _____ Email Address: _____

Please check the program(s) for referral or of interest:

☐ **Parenting Classes** (Parenting Inside Out & Caring Dads)

☐ **Trauma Coping Skill Classes** (Healing Trauma & Building Resilience)

☐ **Spanish language classes** (Parenting Inside Out)

☐ **Youth Mentoring** (for children aged 7-14 with parent/caregiver criminal justice system involvement)

☐ **Early Childhood Home Visiting/Parenting Inside Out 1:1**
(Priority placement for parents/caregivers with children 0-6)

If child(ren) are outside of the home, is transportation set up? ☐ Yes ☐ No

Contact Name : _____

Phone Number for transportation : _____

Needs assessment:
Center advocates and mentors can provide assistance with resources and referrals to help with stabilization.

Identify areas of need below:
☐ Family reunification support
☐ Basic needs (clothing, food, bus tickets, etc.)
☐ Employment/Education
☐ Medical/Dental care
☐ Mental health care
☐ Addiction recovery supports
☐ Peer support /Mentoring
☐ Housing
☐ Not listed: _____

Please complete referral form and email to fax@thepathfindernetwork.org or fax to 503-286-0325