Family Enrichment Services
3941 68th Avenue North ♦ Pinellas Park, FL 33781

REFERRAL FORM

Client Name:		**DOB:**	**Gender:** ☐ Male ☐ Female
Referral Date:		**Medicaid Plan:**	**Medicaid #:**

Other Health Insurance? ☐ **Yes** ☐ **No**

If YES, list all other health insurance policies.

Insurance Plan Name	Policy Holder's Name	Policy Holder's DOB	Policy #

Person referring client: _____ Phone Number:_____

Legal Guardian: _____ Phone Number: _____

Current Caregiver(s) (with whom the client is currently living): _____

Type of Placement: ☐ Biological Parent ☐ Adoptive ☐ Relative ☐ Non-Relative ☐ Foster ☐ Other: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Is child welfare currently involved? ☐ Yes ☐ No If so, please list the case manager information below.

Case Manager Name: _____Phone Number:_____

Case Manager Email Address: _____

Prospective Adoptive Parent(s)?: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email Address: _____

Have the biological parent's rights been terminated? ☐ Yes ☐ No

Are there any current counseling services? ☐ Yes ☐ No (If **yes,** please call to discuss appropriateness of referral)

Have there been previous counseling services? ☐ Yes ☐ No **Reopening services with FES/ARSP?** ☐ Yes ☐ No

Current medication(s)?: _____

Please explain how client is at risk for out-of-home mental health placement: _____

_____

Presenting symptoms or reason for seeking services: _____

_____

Best days/times for appointments: _____

Please indicate all services you are interested in below:

☐ Individual/Family Counseling ☐ Psychiatric Services ☐ Parenting Class

Email this form to
referrals@arsponline.org
or fax to (727) 865-5178
Questions: call 727-657-7761

Keeping Families Together