



**Family Enrichment Services**  
**3941 68<sup>th</sup> Avenue North ♦ Pinellas Park, FL 33781**

**REFERRAL FORM**

<b>Client Name:</b>		<b>DOB:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Referral Date:</b>		<b>Medicaid Plan:</b>	<b>Medicaid #:</b>

**Other Insurance**  Yes  No List all insurance policies, including medical, dental, vision, EAP, and specialty plans:

Insurance Plan Name	Policy Holder	Date of Birth	Type of Plan

Person referring client: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Legal Guardian (if different from referral source): \_\_\_\_\_ 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: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

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

Case Manager Name: \_\_\_\_\_

Case Manager Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Prospective Adoptive Parent(s) (if prospective adoptive placement is pending): \_\_\_\_\_

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 Are you reopening services with FES/ARSP?  Yes  No

If yes, please list agency and dates of counseling: \_\_\_\_\_

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](mailto:referrals@arsponline.org)  
**or fax to (727) 865-5178**  
**Questions: call 727-657-7761**

Keeping Families Together