

**GENESIS II FOR FAMILIES, INC**  
**3036 University SE, Minneapolis, MN 55414**  
**PROGRAM REFERRAL FORM**  
**FAX: 612-617-0193      Phone: 612-617-0191**



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

**CLIENT INFORMATION**

Name \_\_\_\_\_ Birthdate (Age) \_\_\_\_\_  
Address \_\_\_\_\_ Gender \_\_\_\_\_  
\_\_\_\_\_ Ethnicity \_\_\_\_\_  
County \_\_\_\_\_ Marital Status \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_

**REFERRING PARTY**

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

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

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

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

**Behavioral Health Services:**  
\_\_\_\_\_ Parenting Assessment

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

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

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**REASON FOR REFERRAL**

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**CHILD INFORMATION**

**Child Name                  DOB                  Gender                  Ethnicity                  Placement (ex., foster care)**

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**MEDICAL/MENTAL HEALTH**

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

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

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

**LEGAL/LIVING SITUATION**

- On probation                   Child Protection Case Open                   Out of home placement  
 On parole                                   Halfway House                                  (ex., foster care)
- In jail     Residential Treatment                           Independent
- In workhouse                   Transitional Housing                           Other living arrangement

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

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

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**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)**

- |   |   |
|---|---|
| <input type="checkbox"/> Parenting Assessment     | <input type="checkbox"/> Child Protection Case Plan |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Pre-Sentence Investigation |
| <input type="checkbox"/> Court Hearing Report     | <input type="checkbox"/> Other                      |

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

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