**Community Based Family Team Meeting**

**Referral Form**

If you have any questions as you complete this form call Tommy Ross at 515-725-2780

**A community based Family Team Meeting (FTM) is a professionally facilitated meeting that brings together individuals who can assist vulnerable families in getting back on track and preventing any crisis warranting Department of Human Services (DHS) involvement from occurring.**

**This information is CONFIDENTIAL**

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| **Today’s Date:** Click here to enter a date. |

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| **Informed Consent** |
| I have provided the parent(s) of the family in question with information about community based family team meetings and I have obtained their verbal consent to make this referral on their behalf.  **Yes**  **No**   **I am the parent; this is a self-referral** |
| **You cannot make a referral on a family’s behalf until you have obtained their informed consent** |

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| **Referring Person Information –**  *Anonymous referrals cannot be processed* | |
| **Your Full Name:** | **Organization:** |
| **Phone Number:** | **Email Address:** |
| **Your Relationship to Family:** | |

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| **Family Information**  *Please include all known data* | | | |
| **Father’s Full Name:** | | | **Address:** |
| **Phone Number:** | **Email:** | | **City, State, Zip:** |
|  | | | |
| **Mother’s Full Name:** | | | **Address:** |
| **Phone Number:** | **Email:** | | **City, State, Zip:** |
| **Children** | | | |
| **Full Name:** | | **Date of Birth:** | |
| **Full Name:** | | **Date of Birth:** | |
| **Full Name:** | | **Date of Birth:** | |
| **Full Name:** | | **Date of Birth:** | |
| **Full Name:** | | **Date of Birth:** | |
| **Full Name:** | | **Date of Birth:** | |
| **Others Living in the Home** | | | |
| **Full Name:** | | **Relationship to Family:** | |
| **Full Name:** | | **Relationship to Family:** | |
| **Full Name:** | | **Relationship to Family:** | |
| **Full Name:** | | **Relationship to Family:** | |
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| **Is anyone in the family African American?**  **Yes**  **No** | | | |

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| **What is the purpose of the Family Team Meeting?** |
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| **What are the family’s goals for the meeting?** |
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| **Identify safety concerns or risk factors for DHS intervention**  *Check any that apply* | | | | |
| Mental Injury (Emotional Abuse) | | | Child Behavioral Problems | |
| Child Prostitution | | | Domestic Violence | |
| Manufacturing/Possession of Dangerous Substances | | | Family Tragedy/Trauma | |
| Presence of Illegal Drugs | | | Financial Stress/Unemployment | |
| Sexual Abuse | | | Homelessness | |
| Bestiality in the Presence of a Child | | | Parental Mental Health Instability | |
| Physical Abuse | | | Parenting Concerns | |
| Denial of Critical Care (Neglect) | | | Criminal Activity | |
| **If any items in this column are checked, you must call DHS at 1-800-362-2178**  **See definitions of these terms at**<http://www.dhs.iowa.gov/Consumers/Safety_and_Protection/Abuse_Reporting/ChildAbuse.html> | | | Substance Abuse | |
| Other: | |
| **What formal services/supports have been or are being provided to this family?**  *Check any that apply* | | | | |
| DHS Intervention | Mental Health or BHIS Services | | | Homeless Shelter |
| Support Group/Recovery Sponsor | Legal Services | | | Parole/Probation Officer |
| Domestic Violence Services/Shelter | Financial Assistance | | | Other: |
| **What informal supports available to the family?**  *Check any that apply* | | | | |
| Relative(s) | | Children’s School | | |
| Neighbor(s) | | Friend(s) | | |
| Faith Community | | Other: | | |

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| **Other comments or pertinent information?** |
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| **Who would you suggest to invite to this family team meeting?**  *The family may reject your suggestions if they choose to do so* | | | |
| **1** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |
|  | | | |
| **2** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |
|  | | | |
| **3** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |
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| **4** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |
|  | | | |
| **5** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |
|  | | | |
| **6** | **Full Name:** | | **Address:** |
| **Phone Number:** | **Email:** | **City, State, Zip:** |
| **Relationship to family:** | | |

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| **Submit this form via one of the following secure methods**  *This form and all information on it is confidential – Send with care via only these methods* | |
| **Save and attach to email**  [tross@dhs.state.ia.us](mailto:tross@dhs.state.ia.us) | **Print and fax**  515-725-2899 |

**After this referral form is submitted, you will receive a follow-up call to verify the information.**

**This information will be used to help determine if the family in question is a good candidate for a FTM and, if one is to occur, which professional facilitator would be the best match for this FTM.**

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| **DO NOT COMPLETE: Office Use Only** |
| Date Accepted: Click here to enter a date. |
| Facilitator Assigned: |
| Date Facilitator Assigned: Click here to enter a date. |