



# PROVIDENCE HOUSE, INC

2037 West 32<sup>nd</sup>  
Cleveland, OH 44113

## Fax Inquiry and Referral Form

For Providence House use only: Record of Follow-up Contact with Client:

Date and Time of Contact	Summary of Contact

- If you are interested in information about placement availability, services provided or general programming information please complete **Section 1**.
- If you would like to make a referral for placement of a child please complete **Section 2**.

**Fax your completed form to:** (216) 961-7585 Attention: Advocacy Manager

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Name of Person Taking Referral: \_\_\_\_\_

### SECTION 1- INQUIRY FOR AVAILABLE PLACEMENT INFORMATION

Agency: _____	
Phone: _____	Fax: _____
Name: _____ Title: _____	
Phone: _____	Fax: _____ Email _____
<input type="checkbox"/> Please call me regarding availability of space <input type="checkbox"/> Please call me regarding services provided <input type="checkbox"/> Please call me regarding general child programming information	

### SECTION 2 - REFERRAL FOR IMMEDIATE PLACEMENT

Name of Parent or Guardian: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address of Parent or Guardian: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Pager # \_\_\_\_\_

Shelter name: \_\_\_\_\_ Shelter phone: \_\_\_\_\_

**Referring Agency:** \_\_\_\_\_

Agency phone number: \_\_\_\_\_

Case Worker: \_\_\_\_\_ Phone number: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Cuyahoga DCFS Involvement?** Yes  No  If yes, does family have a safety plan? Yes  No   
 Type of custody: Open  Temporary  Other  Case opened: \_\_\_\_\_

Cuyahoga DCFS Caseworker \_\_\_\_\_ phone: \_\_\_\_\_

Cuyahoga DCFS Supervisor: \_\_\_\_\_ phone: \_\_\_\_\_

**REFERRAL REASONS (please check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Homeless type 1: <b>evicted</b>   | <input type="checkbox"/> Adoption Plan  |
| <input type="checkbox"/> Homeless type 2: <b>unsafe living conditions</b>                              | <input type="checkbox"/> Medically stable child need stepped down from a medical facility |
| <input type="checkbox"/> Drug or Alcohol treatment (inpatient or outpatient programs)                  | <input type="checkbox"/> Child at risk for neglect  |
| <input type="checkbox"/> Domestic Violence   | <input type="checkbox"/> Child at risk for abuse  |
| <input type="checkbox"/> Mental Health (inpatient or outpatient treatment programs)                    | <input type="checkbox"/> Short term incarceration in limited circumstances                |
| <input type="checkbox"/> Parent or guardian medical treatment (inpatient, outpatient or home recovery) | <input type="checkbox"/> MR/DD crisis respite   |

Do you anticipate parent/guardian reunification with this child(ren)? Yes  No

**CHILDREN BEING REFERRED FOR RESIDENTIAL PLACEMENT**

Name of Child	Date of Birth	Gender	Clothing Size (including shoes)	Comments on Special Needs

Do any of the above children need transported to school or therapy programs? Yes  No

**If "yes" please list:**

- School name/therapy program: \_\_\_\_\_
- Contact person: \_\_\_\_\_
- Address and phone number: \_\_\_\_\_
- Days of the week and time program attended: \_\_\_\_\_

**LENGTH OF STAY: Approximately how long will this child(ren) need placement?**

- { } 24 hours      { } 48 hours      { } 1 week      { } 2 weeks  
 { } 30 days      { } 45 days      { } 60 days

<b><u>Interoffice use only</u></b>	
Place child immediately? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Place child on waiting list? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Approximate date of admission _____	
Actual Child Placement Date: _____	