Providence House
Every child is your child.™

PROVIDENCE HOUSE, INC

2050 West 32nd
Cleveland, OH 44113

Fax Inquiry and Referral Form

Notes (Providence House Use Only):

Name of Providence House staff taking inquiry: _____ **Date:** _____

Email your completed form to Kendra Sowards, Intake Coordinator, at kendra@provhouse.org
You may also phone-in a referral by calling Kendra at 216-651-5982 x509 with the following information.

SECTION 1 - REFERRAL FOR PLACEMENT

Referring Agency: _____ Date: _____

Case Worker: _____ Phone number: _____

Name of Parent or Guardian: _____ DOB: _____

Address of Parent or Guardian: _____

Home phone: _____ Cell phone: _____ Additional Contact #: _____

How many children are being referred for placement? _____ *(please complete Section 3 for each child)*

Is the parent/family in a shelter? Yes ☐ No ☐ If yes:

Shelter Name: _____ Shelter Phone: _____

Cuyahoga DCFS Involvement? Yes ☐ No ☐ If yes, does family have a safety plan? Yes ☐ No ☐
Cuyahoga DCFS Caseworker: _____ Phone: _____

REFERRAL REASONS (please check all that apply and circle specifiers where appropriate)

- ☐ Homeless: shelter, eviction issues, doubled up
- ☐ Unsafe Living Conditions: general/pests, no utilities
- ☐ Substance Abuse Treatment: inpatient or outpatient
- ☐ Mental Health Treatment: inpatient or outpatient
- ☐ Medical Treatment: inpatient or outpatient for guardian or medical needs of a child, chronic
- ☐ Respite: mental health, overwhelmed parent sobriety maintenance
- ☐ Adoption Plan
- ☐ Violence: community, domestic
- ☐ Child Abuse: preventative, responsive
- ☐ Neglect: responsive, medical
- ☐ Short term incarceration
- ☐ Resource gap: cash/income, benefits

APPROXIMATE LENGTH OF PLACEMENT REQUESTED

☐ 24-72 hours ☐ 1-3 weeks ☐ 30 days
☐ 45 days ☐ 60 days ☐ 90 days (only for inpatient medical/mental health treatment or incarceration)

Comments: _____

SECTION 3 – CHILD BEING REFERRED FOR PLACEMENT

Please fill out one section for each child (birth to age 10) being referred for placement.

Name of Child: _____ Date of Birth: _____
Child's Gender: _____
Child's Clothing Size: _____ Child's Shoe Size: _____

Is this child in school? Yes ☐ No ☐ If yes,
Name of School: _____ Grade: _____ School's Phone Number: _____
School's Address: _____
Is transportation provided to the school? Yes ☐ No ☐

Is this child in therapy or receiving community services? Yes ☐ No ☐ If yes,
Name of Program/Agency: _____ Type of Service: _____
Case Worker Name: _____ Contact Number: _____
This service would be: Onsite ☐ Offsite (transportation is needed) ☐

List any diagnoses the child has and behaviors associated with each:
_____
_____
_____

List any medications the child is currently taking and what the medication is for:
_____
_____
_____

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