APPENDIX B13

Parenting and Mentoring Services Referral Form

Client/Case Name: _____ RID#_____ Phone #: _____

Address: _____

Is the child in out of home placement? Y/N _____ If yes, name of the placement_____

Parent/Caregivers name: _____DOB:_____ Race/Ethnicity: _____

Parent/Caregivers Phone #: _____ Best time to contact: __ Daytime ___ Evening ___Weekend

Emergency contact Person: _____ Phone #:_____

First and last name of the children in the household	DOB	Sex M/F	Race/ Ethnicity	RID#	CMH Diagnosis Y/N	CTSS Eligible Y/N	CADI Waivers Y/N

Please select the provider agency:

Parenting Services

____Ain Dah Yung ____African American Family Services ____CLUES
____FamilyWise (Genesis II) ____Hmong American Partnership ____Lao Family Inc
____ Lifetrack ____ My Home ____Neighborhood House
____ People Inc. ____ Progressive Individual Resources ____Su Familia
____ Wilder ____ YWCA St. Paul

Parents and/or children with an intellectual or developmental disability:

____ Dungarvin ____ New Found Abilities ____ Orion ____REM

Mentoring Services

_____180 Degrees _____ Hmong American Partnership
_____ Lao Family Community, Inc. _____ Neighborhood House

Number of hours and length of time requested: **Expected Start Date:** **Expected Discharge Date:**
Up to ___ hours per week for ___ week's _____ _____

Overall Service Objective:

_____
_____

Individual service goals:

_____
_____
_____

Expected behavior change:

_____
_____
_____

Please elaborate and provide rationale for the services and total hours needed:

_____

_____

_____

Information needed in the progress report _____

_____

Parenting Services only:

Eligibility Criteria

- Families with a reunification plan where intensive or regular in-home services are needed
- Families that have children who are at imminent risk of out of home placement
- Indian Child Welfare (ICWA) cases where active efforts are needed
- Families at risk of out of home placement where in home parenting services are likely to prevent placement

Safety Threats (behaviorally describe): _____

_____

_____

Behavior that needs to change (behaviorally describe): _____

_____

_____

Other information: _____

_____

_____

Mentoring Services Referrals

Briefly describe why the child is being referred for the mentoring services:

_____

_____

The child/youth's Case Manager/Social Worker will meet with the child, parent(s) and the provider agency to set expectations for services and needed behavioral changes before the service begins. Agreed upon service components, including goals and objectives of service, will be incorporated into the client's case plan. If services are terminated by RCCHSD, the child/youth's Social Worker must inform the mentor agency immediately to discontinue service. Any service changes or service extension requests will only be authorized if they meet client need, are within available County revenue and have signed supervisory approval.

CP or Social Worker: _____ Unit: _____

Phone: _____ Fax#_____ Email: _____

Date form completed: _____

Signatures:

_____	_____	_____
CP or Social Worker	Date	Phone
_____	_____	_____
Worker's Supervisor	Date	Phone

For Parenting Services Referrals:

_____	_____	_____
Authorizing Manager	Date	Phone

Please fax, email or mail bills and monthly progress reports to:
Julie Jones at 160 East Kellogg St. Room 6000 Saint Paul MN. 55102
Email: julie.jones@co.ramsey.mn.us Fax: 651-266-3702