FaCT Family Resource Center Referral Form for Family Support Services

CLEAR ALL FIELDS

To refer a client for services, EMAIL this form to the FRC selected below (choose **one** FRC)

Referring Person/Worker Name:	Agency/Department:	Email:
Work Phone:	Fax:	Date:

Referral type: ☐ CalWORKs Family Stabilization (FS) ☐ Differential Response (DR) ☐ General FRC | **Check if applicable:** ☐ Wraparound ☐ Mutual Client

☐ **Anaheim Independencia FRC** - *Anaheim* T (714) 826-9070 F (714) 826-2732 **FS** AnaheimIndependenciaFRC@factoc.org	☐ **CHEC FRC** - *San Juan Capistrano* T (949) 489-7742 F (949) 489-7748 **FS** CHECFRC@factoc.org	☐ **Corbin FRC** - *Santa Ana* T (714) 480-3737 F (909) 366-2257 CorbinFRC@factoc.org	☐ **Downtown FRC** - *Santa Ana* T (714) 660-3636 F (714) 542-4853 DowntownFRC@factoc.org
☐ **El Modena FRC** - *Orange* T (714) 532-3595 F (714) 532-3593 ElModenaFRC@factoc.org	☐ **Friendly Center-Orange FRC** -*Orange* T (714) 771-5300 F (714) 771-7627 FriendlyCenterOrangeFRC@factoc.org	☐ **La Habra FRC** - *La Habra* T (714) 447-3460 F (714) 447-3753 LaHabraFRC@factoc.org	☐ **Magnolia Park FRC**- *Garden Grove* T (714) 741-5222 F (714) 530-7908 MagnoliaParkFRC@factoc.org
☐ **Manzanita Park FRC** - *Anaheim* T (714) 491-7205 ManzanitaParkFRC@factoc.org	☐ **Minnie Street FRC** - *Santa Ana* T (714) 972-5775 F (714) 972-5781 MinnieStreetFRC@factoc.org	☐ **Newport Mesa FRC** - *Newport Beach* T (949) 764-8100 F (949) 764-4543 **FS** NewportMesaFRC@factoc.org	☐ **Oak View FRC** - *Huntington Beach* T (714) 842-4002 F (714) 842-4184 OakViewFRC@factoc.org
☐ **So. Orange County FRC** - *Lake Forest* T (949) 364-0500 F (949) 364-0575 SouthOCFRC@factoc.org	☐ **Stanton FRC** - *Stanton* T (714) 379-0129 F (714) 379-0139 StantonFRC@factoc.org	☐ **Tustin FRC** - *Tustin* T (714) 243-4292 F (714) 838-1403 TustinFRC@factoc.org	☐ **Westminster FRC** - *Westminster* T (714) 903-1331 F (714) 903-1881 **FS** WestminsterFRC@factoc.org

Primary or Identified Client(s) to be served:

Parent/Caregiver Name:			DOB:	Insured?: ☐ Emergency Medi-Cal ☐ None ☐ Medi-Cal ☐ Private
Address:	City:	State: Zip:		Phone:

Other Family Members to Be Served:

Name:				
D.O.B:				
Relationship:				

CIN # (12 Digits):	CalWORKs Case # (7 Digits):	CFS Referral # (19 Digits):

CWS Service Component: ☐ VFS ☐ ER ☐ DR ☐ FM ☐ FR ☐ PP

Social Worker Name: Email: Phone:

☐ Case Management Team	☐ After-School Programs	☐ Legal/Immigration Resources
☐ Counseling for _____	☐ Emergency Assistance	☐ LGBTQAI+ Resources
☐ Domestic Violence Personal Empowerment Program	☐ Family Engagement Activities	☐ Military/Veteran Resources
☐ Family Support Services	☐ Health & Wellness Services	☐ New Parent Services
☐ Information & Referral	☐ Healthy Tomorrows Program	☐ Public Assistance Resources (CalWORKs/CalFresh)
☐ Parent Education	☐ Housing	☐ Teen/Youth Programs
	☐ In-home Parenting (0-5)/Family Support	☐ Other _____

Does this case need a bilingual worker? ☐ No ☐ Yes *If Yes, please specify language:*_____

Does FRC staff need to speak with the referring party prior to intake? ☐ No ☐ Yes

☐ DR Only: Client Declined Initial Referral*

* *FRC DR staff* to follow up with second/third attempt ☐ Phone Call ☐ Mailed Info

Reasons for Referral/Additional Information: ***Please list any "red flags" that may be present***

Service Agreement and Authorization to Release Information:

The referring party has explained to me the purpose for this referral. I agree to be contacted by FRC staff and have a copy of this referral faxed or to take a copy of this referral to the Family Resource Center. I agree to attend any scheduled appointments with the Family Resource Center.

I authorize the release of information between _____(referring agency) and SELECT (above indicated Family Resource Center) for the period this service agreement remains in effect. This information will pertain to the reasons for referral and presenting problem and will be used for consultation, evaluation, assessment, and treatment of the client(s) to be served. Information may also be released to the Orange County Social Services Agency for program evaluation and/or State-required reports. *This referral was explained to me in my primary language.*

Client Signature Date ☐ Verbal consent received

Referring Person Signature Date ☐ Verbal consent (print/type name in lieu of signature)

Assigned FRC Staff/Program:

8.25.2020