Holy Family Institute
Family Focused Referral Sheet
Phone: 412-766-9020 x1222
Fax to: 412-766-0476
Email to: ffsbreferrals@hfi-pgh.org

Date: _____

Referral Source Name: _____ Agency: _____

Email Address: _____ Phone #: _____

(IP) Client's Name: *(must be the parent)* _____

Gender: _____ DOB: _____ Social Security #: _____

Cell Phone #: _____ Home/Work Phone #: _____

Address: _____

Other family members in the home: _____

_____

Insurance – (ONLY PA State Medicaid/Medical Assistance accepted):

Insurance Name: _____ ID #: _____ State ID #: _____

CYF Case Worker: (if applicable): _____

Phone #: _____ Email: _____

Any current Mental Health services for IP? ___ Yes ___ No How frequent? _____

Is there a mental health diagnosis? ___ Yes ___ No Diagnosis: _____

Provider Name: _____ Phone #: _____

Other services in the home? ___ Yes ___ No Service type: _____

Are the children in the home or is there a reunification goal set for 30-45 days from now? ___ Yes ___ No

If reunification, when is the next court date? _____

Is the IP working? ___ Yes ___ No What is the IP's schedule? _____

(Family Focused is an in-home program for at least 6 months with mandatory sessions 2 times a week)

What is the IP struggling with? _____

_____

_____

What is the child(ren) struggling with? _____

_____

_____