HOMELESS CHILDREN'S NETWORK

REFERRAL FOR SERVICES

Date Submitted: _____

Child or Client's Name: _____**DOB:** _____

Preferred Name: _____

MediCal Number or SSN: _____(Required for EPSDT programs)

(medi-cal # usually begins with a "9" and always includes a letter)

Caregiver's Name/ Relationship: _____

Client/Child's Address/Location: _____

Caregiver Contact: _____

REASON FOR REFERRAL Issues that child/client/family members are facing (in their words or as you observe)**:**

_____

_____

Has the client/family witnessed an act/s of Violence in the home, school or community that has significantly impacted the client/family's life? Please check one**: Yes___No____**

If "Yes" briefly describe: _____

Specific needs or concerns (i.e. language/disability)? _____

***Is the client/family seeking cultural specific/relevant therapeutic services? Yes_____No____**

If "Yes", please describe:_____

Is there anyone in this family who has been a client of HCN (past/present)? Yes_____No____

If "YES", Name(s):_____

Child's School/Care Center: _____

Is the client receiving SPED Services? Check all that apply: ⬜ **IEP** ⬜ **ERMHS** ⬜ **SDC**

Referred by: _____Agency Name: _____

Title: _____Phone: _____Email: _____

Program: ⬜ **General EPSDT** (Mental Health/ Behavioral Health services) ⬜ **Ma'at EPSDT** (Afri-centric MH services)

Brighter Futures: ⬜**Individual** ⬜**Group** (Therapeutic Service for fathers who identify with the black/african diaspora)

⬜**Training Program** (School-based internship services) ⬜**Case Management Services**

***Email referrals to clientreferrals@hcnkids.org or Fax to (415) 437-3994**

Questions about a referral? Email: Kaley Berlin, Clinical Director, kaley.berlin@hcnkids.org

**Please note that while we will do our best to match client/family needs, matching is not guaranteed.*

CONFIDENTIAL