Referral for Services

Email form to samantham@cafaweb.com or fax 541-344-8239

Client Information

Name

Date of Birth

Phone Number

Incident date

Referral Date

Name of Caseworker

Caseworker Email

Client's Address

How will the client pay for services?

- Cash
- DHS Contract for BIP (DV)
- Medicaid
- Unsure

Referral type

- Domestic Violence (36)
- Anger Management (36)
- Parenting After Crisis (15)

Order type

- No Contact
- No Offensive Contact
- Restraining Order
- No Stalking Order
- Other or N/A

Order with

- Child(ren)
- Partner
- Other or N/A

Has this person violated a contact order or RO in the past?

- Yes
- No
- Unsure

Does the client have a history of trauma?

- Yes
- No
- Unsure

Are they intellectually impaired?

- Yes
- No
- Unsure

Is this their first DHS case?

- Yes
- No
- Unsure

Was this a drug/alcohol related incident?

- Yes
- No
- Unsure

Presenting Situation/ DHS' Areas of concern (attach additional documents if needed):

Treatment goals specific to client:

What track is the client on?

- Reunification
- Adoption
- Termination
- Other

Child(ren) placed with:

- Other parent
- In home with client
- With other family members
- Foster Care

Are visits currently taking place?

- Yes
- No
- Other

Has the client had any past involvement with the criminal justice system? Previous DV charges? Previous DHS Cases? Please explain.

What do you believe is one of the client's strengths?

DHS incident report & ROI attached to referral?

Yes

No

Does client have a sex offense or have there been allegations of sexual abuse? If yes, please refer client to another agency for services.

No Yes

Recommendation: Client is referred to CAFA for treatment. Client is to fully participate, successfully complete, and fulfill payment obligations for services rendered at CAFA.

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