



Referral for Services

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

Client Information

Name	Date of Birth	Phone Number	Incident date
	<input type="text"/>		<input type="text"/>

Referral Date	Name of Caseworker	Caseworker Email
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Client's Address	How will the client pay for services?
	Cash DHS Contract for BIP (DV) Medicaid Unsure

Referral type	Order type
Domestic Violence (36) Anger Management (26) Parenting After Crisis (15)	No Contact No Offensive Contact Restraining Order No Stalking Order Other or N/A

Order with	Has this person violated a contact order or RO in the past?	Does the client have a history of trauma?
Child(ren) Partner Other or N/A	Yes No Unsure	Yes No Unsure

Are they intellectually impaired?	Is this their first DHS case?	Was this a drug/alcohol related incident?
Yes No Unsure	Yes No Unsure	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?

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

Yes

No

Yes

No

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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