

REFERRAL TO THE FEDERATION OF FAMILIES OF SOUTH CAROLINA

FAMILY CONTACT INFORMATION:

NAME (PARENT/GUARDIAN) _____

ADDRESS _____

STATE _____ ZIP _____ COUNTY _____

PHONE _____

CHILD'S NAME _____ CHILD'S DOB ____/____/____

CONSENT FOR RELEASE OF CONTACT INFORMATION— SIGNATURES REQUIRED

_____ PARENT/LEGAL GUARDIAN

_____ CHILD IF OVER 16 YEARS OF AGE

REFERRAL SOURCE CONTACT INFORMATION:

NAME _____

AGENCY _____

PHONE _____

E-MAIL _____

COUNTY _____

DATE GAIN SS ADMINISTERED

REASON FOR REFERRAL _____

AGENCIES OR SYSTEMS KNOWN TO BE INVOLVED WITH THE FAMILY:

PLEASE CHECK WHICH SYSTEMS ARE INVOLVED IN DELIVERING SERVICES TO YOUR CLIENT

- | | |
|--|---|
| <input type="checkbox"/> MENTAL HEALTH | <input type="checkbox"/> HOMELESS SERVICES |
| <input type="checkbox"/> CONTINUUM OF CARE | <input type="checkbox"/> JUVENILE JUSTICE |
| <input type="checkbox"/> DSS | <input type="checkbox"/> PROBATION/FAMILY COURT |
| <input type="checkbox"/> EDUCATION | <input type="checkbox"/> HOUSING |

TO COMPLETE THE REFERRAL:

PLEASE FAX REFERRAL FORM TO 803-772-5212

QUESTIONS— CALL TOLL FREE 1-866-779-0402



FEDERATION OF FAMILIES OF SC
810 DUTCH SQUARE BLVD STE 205
COLUMBIA, SC 29210 803-772-5210
WWW.FEDFAMSC.ORG



US DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION - CENTER FOR MENTAL HEALTH SERVICES
WWW.SAMHSA.GOV