Children, Youth & Families Department
STATE OF NEW MEXICO
Prevention & Initiatives Bureau

Community Based Prevention, Intervention and Reunification Services
Referral

Please provide as much detail as possible and include all required attachments. If this is a CYFD referral, include copies of the most recent safety assessment, risk assessment, CARA plan, and current safety plan, if applicable. If an area does not apply to a family, put N/A. Any missing information may delay the scheduling of a warm hand-off.

1. Referring Partner Information:
Date: _____ Employee Name/Title: _____Referring Agency:_____

Phone Number: _____Email Address: _____

2. Family's Information:
Primary Caregiver Name: _____ _____ DOB: _____

Personal Phone #: _____ Email Address: _____

Relationship to Child(ren) _____

Address/Directions: _____

_____

Secondary Caregiver Name: _____DOB: _____

Personal Phone #: _____ Relationship to Child(ren)_____
Address/Directions:

FACTS # (*If known*) _____ Family's Primary Language: _____

FCM Scheduled? ☐Yes ☐No If yes, Date:_____ Location:_____

Court Date Scheduled? ☐Yes ☐No If yes, Date: _____ Location: _____

Is the family aware that this referral was made? ☐ Yes ☐ No

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Please list all household members whom the program will work with, including all children:

First Name	Last Name	Date of Birth	Relationship

Reason for referral/Summary of Family's Situation:

Supports available to the family (family members, friends, other service providers working w/ family, etc.)

Family Support	Relationship	Contact Information

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CYFD History *(if applicable)*:

FOR CYFD ONLY:
(Complete this section if the children are in CYFD custody)

Are any of the children in CYFD Custody? ☐ Yes ☐ No If yes, date of custody: _____

Trial Home Visit Date: _____ Transition Calendar: ☐Yes ☐No *(If yes, please attach)*

Foster Parent Name: _____ Foster Parent Phone: _____

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Reason for Custody:

Attach the following to the referral:
(*Any missing information will delay the scheduling of a warm hand-off*)

- ☐ Affidavit
- ☐ Most recent Bio-Psycho-Social Assessment
- ☐ Most recent treatment plan

I certify that the referral was discussed with the family and that the information on this form was completed to the best of my knowledge.

Agency Employee Signature _____ Date _____

For the community-based agency only:

Date referral received: _____ Date of Warm Handoff: _____