# SAFE INTENSIVE MEETING REFERRAL

**REFERRAL REQUIREMENTS: Completed referral packets should be sent via email or fax and must include a completed Multi-Agency Referral and Client Release of Information Form 815. SAFE Coordinators will not start communicating between agencies, speaking with families and scheduling a meeting, without a completed Form 815.**

**Email: behavioralhealth.safe@co.slo.ca.us** **Fax: 805-474-2025** **Referral Date:_____**

| ***Referral Source Information-*** | |
|---|---|
| Referring Party Name: | Referring Agency: |
| Phone Number: | Email: |
| Has the child/family been previously referred to SAFE? ☐ Yes ☐ No | Date: |
| Was the referral for Family Advocate or SAFE Intensive Meeting? | |
| Interpretation Services Needed: ☐ Yes ☐ No | Preferred Language: |
| Is the referring party able to provide Interpretation Services for the meeting? ☐ Yes ☐ No | |
| Any additional accommodations needed: ☐ Yes ☐ No | Please Note: |
| Is the family aware of the referral being submitted to SAFE? ☐ Yes ☐ No | |

| ***Child/Client Information-*** | |
|---|---|
| Legal Name: | Preferred Name (if different): |
| Date of Birth: | Ethnicity: |
| Home Address: | Phone Number: |
| School Name: | Grade: |
| Current School Placement (if different): | |
| Does the child have an Individualized Education Plan (IEP)? Yes ☐ No ☐ | 504 Plan? Yes ☐ No ☐ |

| ***Parent/Legal Guardian/Family Information-*** | |
|---|---|
| Mother's Legal Name: | Preferred Name (if different): |
| Date of Birth: | Ethnicity: |
| Home Address: | Phone Number: |
| Father's Legal Name: | Preferred Name (if different): |
| Date of Birth: | Ethnicity: |
| Home Address: | Phone Number: |
| Legal Guardian's Name (if different from parents): | |
| Relationship to child: | Date of Birth: |
| Home Address: | Phone Number: |
| If parents are separated, parent with whom child is currently living with: | |
| Who is the main point of contact for the SAFE Meeting: | |

| ***Please list all known siblings of the client, regardless of age-*** | | | |
|---|---|---|---|
| *Name:* | *Date of Birth:* | *School:* | *Living in the same home?* |
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| ***Referral Information-*** |
|---|
| Please identify child and family strengths and/or what is going well within the family system: |
| Please briefly summarize family's current needs/circumstances for a SAFE Intensive Meeting: |
| What would the Referring Party like to see happen at the meeting? |
| What would the Family like to get out of the meeting? |
| What will be helpful for the SAFE Committee to know/consider when providing information at the meeting? |
| What current services or agencies is the child/family connected to? |

| *Name:* | *Phone:* | *Email:* | *Agency/Title:* |
|---|---|---|---|
| Therapist- | | | |
| School Counselor/PEI Counselor- | | | |
| DSS Social Worker- | | | |
| Housing Authority (HASLO)- | | | |
| Other: | | | |

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| If known, please indicate if the child or family qualifies for the following- Medi-Cal, CalWORKs, CalFresh, etc.: |
| In known, please indicate private insurance provider information: |
| Please list or summarize any known barriers the family has experienced in identifying or accessing services: |

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