Lead4Life

www.Lead4lifeinc.org

Parent Mentoring Initiative (PMI) Referral Form

2096 Gaither Rd, Suite 110, Rockville, MD 20850

240-499-8949 (Telephone) PMI@lead4lifeinc.org (Email)

~Please complete the entire form~

DSS County: ____

Date of Referral: _____________ Referred By (Name/Title/Agency): __________________________________

Phone: _______________________________ Email: ____

Relationship to Family/Parent: ☐ Parent Attorney ☐ DSS Social Worker ☐ Child Attorney ☐ Other: _____________

☐ Parent Attorney ☐ DSS Social Worker- Name/Agency: ____

Phone: _______________________________ Email: ____

Shelter Care Hearing /CINA Date: ________________ Adjudication/Disposition Date: ____________________

Permanency Planning Hearing: ________________ Review Hearing: _________________________________

TPR/Guardianship Hearing: ___________________ Other (please specify): ____________________________

Safety Risks: ____

PARENT INFORMATION

Name: (First/Last): ____ D.O.B./Age: _______________

Relationship to Child: ____

Gender: _______ Race: _______ Ethnicity: ________ Primary Language: ____________

Address: ____

(Street) *(Apt #)* *(City)* *(State & Zip Code)*

Phone: ____________________________ E-mail: ____________________________

Other Parent Name: (First/Last): _______________________________________ D.O.B./Age: ___________

Relationship to Child: ____

CHILD(REN) INFORMATION

Child's Name (First/Last): ___________________________ D.O.B./Age: _______________

Gender: _______ Race: _______ Ethnicity: ________ Primary Language: ____________

☐ Foster Home ☐ Kinship Placement ☐ Residential: ___________

☐ Biological Family ☐ Adoptive Family ☐ Other: ______________

Child's Name (First/Last): ___________________________ D.O.B./Age: _______________

Gender: _______ Race: _______ Ethnicity: ________ Primary Language: ____________

☐ Foster Home ☐ Kinship Placement ☐ Residential: ___________

☐ Biological Family ☐ Adoptive Family ☐ Other: ______________

Child's Name (First/Last): ___________________________ D.O.B./Age: _______________

Gender: _______ Race: _______ Ethnicity: ________ Primary Language: ____________

☐ Foster Home ☐ Kinship Placement ☐ Residential: ___________

☐ Biological Family ☐ Adoptive Family ☐ Other: ______________

PARENT/CLIENT / NEEDS & OTHER INFORMATION

It is helpful for us to have as much information on the parent/client you are referring so we can assign him/her to a service/mentor who can best serve their needs. Please provide as much information as possible in this section.

Has the parent/client had a previous psychological evaluation? ☐ YES ☐ NO If so, completed: _____

Has the parent/client been hospitalized in the past 6 months? ☐ YES ☐ NO If so, where and duration of stay: _____

Has the parent/client been detained in the past 6 months? ☐ YES ☐ NO If so, what was the reason: _____

Does the parent/client have any other special communication needs? ☐ YES ☐ NO If so, please explain: _____

What are the current symptoms promoting the request for service and/or mentor (check all that apply)?

- ☐ Anxiety
- ☐ Depression
- ☐ Withdrawn/Poor Social Interaction
- ☐ Mood Instability
- ☐ Psychosis or Hallucinations
- ☐ Bizarre Behavior
- ☐ Unprovoked Agitation or Aggression
- ☐ Self-Injurious Behaviors
- ☐ Inattention
- ☐ Hyperactivity
- ☐ Possible Autism
- ☐ Lack of family support
- ☐ Other: _____

PARENT/CLIENT DOCUMENT & ADDITONAL INFORMATION

- ☐ CINA Petition **(Required)**
- ☐ Adjudication/Disposition Decision/Order **(Required)**
- ☐ Service Summary **(Required)** Purpose of Referral/what specific goals/needs are PMI sought for
- ☐ DSS Service Agreement
- ☐ FIM Report
- ☐ Safety Plan
- ☐ Other/Additional Information: _____

Please feel free to provide us with any additional information not included in your documents provided to Lead4Life you think may be helpful to us in providing services to this family:

_____

_____

_____

_____

L4L INTERNAL USE ONLY

Reviewed by: _____ Date: _____

Intake date: _____

Assigned to: _____ Date: _____

Comments: _____

Confirmation of Services to (mentor/billing/referral source): _____ Date: _____

☐ Phone call ☐ Email ☐ Text

We appreciate you taking the time to complete this referral form and for giving us the opportunity to serve the family. Please feel free to call/e-mail us with any questions or concerns.