Horizons
A FAMILY SERVICE ALLIANCE

Family Support Worker Referral/Intake Form

Referral Agency: _____ Referring Person: _____
Phone Number: _____ Email: _____

Does the family know a referral is being made? _____ Release signed? _____

Parent Name: _____
Address: _____
Phone: _____
Note safety concerns related to calling the client: _____

Family Members:

Name	Age	DOB	Sex	Ethnicity	School/Daycare	Grade	Health Insurance

Household Presenting Issues:

- ☐ Basic Needs
- ☐ Child Care
- ☐ Legal Problems
- ☐ Domestic Violence
- ☐ Child Abuse/Neglect
- ☐ Parent Hx physical abuse
- ☐ Parent Hx sexual abuse
- ☐ Employment
- ☐ Financial
- ☐ Health
- ☐ Housing
- ☐ Lack of support
- ☐ Mental Health Issues
- ☐ Parenting
- ☐ Relationship Issues
- ☐ School problems
- ☐ Substance Abuse
- ☐ Teen Parent
- ☐ Transportation
- ☐ Language Barrier
- ☐ Literacy
- ☐ Pregnancy

Additional Information (attach additional sheet if necessary)

_____
_____
_____
_____
_____
_____
_____

Send completed form to:

Horizons, A Family Service Alliance
819 5th St. SE
Cedar Rapids, IA 52401
Fax: 319-398-3577

Horizons Use Only:

Referral Date: **Referral Received:** **Intake Date:**