harmony family center
so children may live their best lives

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Referral Date		**Region**		**Person Making Referral**			
Child's Name		**DOB**		**Gender**		**Ethnicity**	
Date of Custody		**Date of Guardianship**		**SSN**			
Resource Parent 1				**Cell Phone**			
Resource Parent 2				**Cell Phone**			
Address					**Zip**		
City		**County**					
Home Phone		**Email**					

Type of Placement					
Foster Placement	☐	Group/Residential	☐	Level 3	☐
Kinship Placement	☐	Level 1	☐	Level 4	☐
Pre-Adoptive	☐	Level 2	☐		

Current Permanency Goal		**Permanency Resource**			
Reunification	☐	**Name**		**Phone (home & cell)**	
Adoption	☐	**Address**			

Service Requested	**Describe specific reason for referral**: (i.e. permanency barriers or issues; focus of requested counseling; topics for professional development/ consultation)
☐ **Child Grief and Loss Counseling**	
☐ **Home Capacity Assessment (please mark type below):** ☐ **Approved home** ☐ **Reactivated home** ☐ **New home**	
☐ **Impact of Family Dynamics on Child**	
☐ **Permanency Parenting Assessment**	

Pertinent Team Members

NAME	AGENCY	TITLE	BEST PHONE	EMAIL

Regional Administrator Signature and Date: