Sierra House
Individual Support Services

Phone: 973-678-3556
Fax: 973-678-2721
Email: referrals@sierrahouse.org

Individual Support Services

Referral Form

Child/Consumer's Information			
Last Name:	**Fist Name:**		**Medicaid #**
D.O.B:	**Gender:**	**Male**	**Female**
Street Address:		**Apt #**	
City:	**Zip Code:**		**County:**

Is this a referral for a child/consumer with additional needs? ☐ **Yes** ☐ **No**

Detail of Referrer		
Agency Name:		
Contact Person:	**Email:**	
Street Address:	**City:**	**Zip Code:**
Office Telephone:	**Cell:**	**Fax:**

Type of Referral

☐ IIH (Intensive in Home Services) ☐ IIC (Intensive in Community Services)

☐ ISS (Individual Support Services) ☐ Mentor Services

☐ Co-Occurring Services (Substance Abuse / Mental Health)

Is parent aware of referral? ☐ **Yes** ☐ **No / Is Child/Consumer aware of referral?** ☐ **Yes** ☐ **No**

Parents/Persons Caring for Child/Consumer

Name	Last Name	Male/Female	Relationship to child

Address:

Phone # **Cell #** **email:**

Significant Others in the Household

Name	Last Name	Male/Female	Relationship to child

Specific reasons for referral (include strengths and difficulties or any specific incidents of concern):

Following Information May Not Be Included in Initial Assessment

Child's first language	
Parent's first language	

Interpreter/ Sign required? ☐ Yes ☐ No If yes, give details:

Agencies/ Collateral Support	
Agency:	**Address:**
Phone #	**Contact Person:**
Agency:	**Address:**
Phone #	**Contact Person:**
Agency:	**Address:**
Phone #	**Contact Person:**
Agency:	**Address:**
Phone #	**Contact Person:**

Is there a perceived risk of violence or other matters that could place those making contact with this family in danger (such as an unsafe environment, someone with a known history of violence to others, a dangerous animal etc.)?
☐ YES ☐ NO If yes, please specify what the identified risk is?

Note: Information provided on this form will be shared with families and collateral supporters, if relevant to assessment and planning, unless indicated otherwise by the referrer.
Signature of referrer: Date:
Signature of parent/Caregiver: Date: