|  |
| --- |
| **Child & Family Services of Northwestern Michigan**  **Safe Haven: Supervised Visitation & Exchange Program**  *Referral Form* |

**REFERRAL INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referring County: | | | Charlevoix  Otsego | Cheboygan  Mackinaw | | | | Emmet  Other: | | |  | | |
|  |  | |
|  | | | | | | | | | | | | | |
| Date of Referral: |  | | | |  | Court Case #: | | |  | | | |  |
|  | | | | | | | | | | | | | |
| Referral Source: |  | | | |  | Contact Name: | | | |  | | |  |
|  | | | | | | | | | | | | | |
| Contact Number: | |  | | |  | Email: |  | | | | | |  |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Next Court Hearing (m/d/y): | | |  | Date of Next Mediation (m/d/y): | | |  |  |
|  | | | | | | | | |
| What type of order is this?  Criminal  Civil | | | | | | | | |
|  | | | | | | | | |
| The court order is:  Final Order  Temporary Order  Not Yet in Place | | | | | | | | |
|  | | | | | | | | |
| Has a Personal Protection Order been issued?  Yes  No  Unknown | | | | | | | | |
|  | | | | | | | | |
| Has a No Contact Order been issued?  Yes  No  Bond Condition  Probation  Unknown | | | | | | | | |
|  | | | | | | | | |
| Has an Abuse/Neglect Order been Issued?  Yes  No  Unknown | | | | | | | | |
|  | | | | | | | | |
| If so, when was it issued (m/d/y)? | |  | | | When does it expire (m/d/y)? | |  |  |
|  | | | | | | | | |
| Restrained Party: |  | | | | Protected Party: |  | |  |
|  | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Service Requested:\***  Supervised Visitations  Safe Exchanges  Reunification | | **Payment:**  Families with a history of **any** of the following: domestic violence, sexual assault and stalking, qualify for OVW Grant funds. | | | | | | |
| **All Others, Payment Responsibility:** | | | | | | |
| Referral Source  Shared Cost | | | | Non-Custodial  Custodial | | |
|  | | | | | | | | |
| Frequency of Visitation/Exchange: |  | | | (times per week) | | | | |
|  | | | | | | | | |
| Number of Hours per Supervised Visit: | | |  | | (hours per visit) | | | |
|  | | | | | | | | |
| Anticipated Length of Supervised Visitation/Exchange service will be | | | | | | |  | months. |
|  | | | | | | | | |
| *\*All services are contingent upon availability.* | | | | | | | | |
|  | | | | | | | | |

|  |
| --- |
| **Safe Haven: Supervised Visitation & Exchange Program**  *Referral Form* |

**FAMILY INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Name of Parent #1:** | | | | |  | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Custodial**   **Non-Custodial** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| DOB (m/d/y): | | | |  | | | | | | Male  Female | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Relationship to child (ren):  Mother  Father  Other: | | | | | | | | | | | | |  | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | City: | | | |  | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| State: |  | | | | | Zip Code: | |  | | | County: | | | | | |  | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | |  | | | | Cell Phone: | |  | | | | | Work Phone: | | | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| Primary Language Spoken:  English  Spanish  Other: | | | | | | | | | | | | | | |  | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Name of Parent #2:** | | | | |  | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Custodial**   **Non-Custodial** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| DOB (m/d/y): | | | |  | | | | | | Male  Female | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Relationship to child (ren):  Mother  Father  Other: | | | | | | | | | | | | |  | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | City: | | | |  | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| State: |  | | | | | Zip Code: | |  | | | County: | | | | | |  | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | |  | | | | Cell Phone: | |  | | | | | Work Phone: | | | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | |
| Primary Language Spoken:  English  Spanish  Other: | | | | | | | | | | | | | | |  | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Children:** | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| Name: |  | DOB (m/d/y): |  |  |
|  | | | | |
| **Safe Haven: Supervised Visitation & Exchange Program**  *Referral Form* | | | | |

**CASE HISTORY**

|  |  |  |
| --- | --- | --- |
| Please check all that apply: | | |
| Domestic Violence  Child Sexual Abuse  Abduction Concerns  Mental Illness | Substance Abuse  Violation of Court Order  Emotional Abuse  Criminal Behavior | Physical Abuse to Child  Reunification  Stalking  Sexual Assault |
| Please explain any of the above checked case issues including other not listed: | | |
| Please explain why services have been ordered, recommended, or agreed upon: | | |
| Please indicate any special issues/concerns Safe Haven staff should be aware of: | | |

|  |  |
| --- | --- |
| **In addition to completing the written referral, please attach the following documents:** | |
|  | * **Copy of Court Order** * **Copy of any Police Reports** * **Any additional helpful information** |

**For additional information, please contact:**

|  |
| --- |
| **Tracy Martin – Safe Haven North Program Coordinator**  **Child & Family Services of Northwestern Michigan**  **3434 M-119, Suite F (Emmet County Health Department)**  **Harbor Springs, MI 49740**  **Phone: (231) 489-8165**  **Fax: (231) 347-8823**  **Email:** [**tmartin@cfs3L.org**](mailto:tmartin@cfs3L.org) |