North County
210 E. Enos Drive #A
Santa Maria CA 93454
Tel: (805) 614-9160
Fax: (805) 614-9363

South County
1236 Chapala St.
Santa Barbara CA 93101
Tel: (805) 965-2376
Fax (805) 963-6707

REQUEST FOR SERVICES

Person requesting services: _____ Date: _____ Time: _____

Referral made by: _ _____
Name/Relationship* Agency Phone Fax

***Is this person currently the child/children's legal guardian/custodian (circle): Yes / No**

CALM offers a number of different services to support the well-being of parents and their children, including early intervention and developmental guidance for young children (0-5 years), treatment to help children overcome the effects of abuse or family violence, and supportive services and education to assist parents. If you are interested in services or would like more information, please complete this questionnaire. Your completion of this questionnaire is voluntary.

***Services requested*:** I am interested in (check all that apply):

- ☐ *Developmental education/support:* Helping my child/children develop to the best of their ability
- ☐ *Positive parenting practices:* Learning ways to manage my child's emotions and behavior
- ☐ *Treatment to support healing:* Helping my children overcome difficult experiences
- ☐ *Individual/couples treatment or support groups for parents:* services to help me cope with/ overcome issues that may affect my parenting

What issues/difficulties have led to this request for services:
_____
_____
_____

Referring Provider Comments:_____
_____
_____
_____

RELEASE OF INFORMATION

Providers: if you would like to discuss the family with CALM staff, please complete this section.

I/We, _____hereby give my/our permission for CALM staff to exchange, obtain, or release information and/or records about (my name and/or child's name).

_____

to or from_____
(Write the name of the referral source named above)

_____ **Valid from:** _____ _____
Client Signature (parent or guardian of child) Start Date End Date

(OVER – please complete the family information on the other side)

Family Information

Please complete with as much information as you have available

Caregivers currently living with child/children	Interested in
Caregiver #1	

	receiving or participating in services?
Name: _____Language: ___Date of Birth: ___ /___/___ Relationship to child/children : Home Phone: _____ OK to leave a message? ____ Work Phone: _____ OK to leave a message? ____ Cell Phone: _____ OK to leave a message? ___ Legal Guardian/Custodian (circle): Yes / No	**Yes / No**
Caregiver #2	
Name: __ _____Language: _____Date of Birth: ___ /___/___ Relationship to child/children : Home Phone: _____ OK to leave a message? ____ Work Phone: _____ OK to leave a message? ____ Cell Phone: _____ OK to leave a message? ____ Legal Guardian/Custodian (circle): Yes / No	**Yes / No**
Address: **City**: **Zip**:	

Children in the home					Services requested for this child?
Name	**Gender**	**Date of Birth**	**SSN**	**Medi-Cal #**	
					Yes/ No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
				Parent currently pregnant?	**Yes / No**

Is custody currently being disputed (circle)? Yes / No / Not applicable

Parents – not currently living with child/children	Interested in receiving or participating in services?
Parent #1	
Name: __ _____Language: _____Date of Birth: ___ /___/___ Home Phone: _____ OK to leave a message? ____ Work Phone: _____ OK to leave a message? ____ Cell Phone: _____ OK to leave a message? ____ Legal Guardian/Custodian (circle): Yes / No	**Yes / No**
Address: **City**: **Zip**:	
Parent #2	
Name: __ _____Language: _____Date of Birth: ___ /___/___ Home Phone: _____ OK to leave a message? ____ Work Phone: _____ OK to leave a message? ____ Cell Phone: _____ OK to leave a message? ____: Legal Guardian/Custodian (circle): Yes / No	**Yes / No**
Address: **City**: **Zip**:	

For Direct Child Welfare Referrals	
North County - Program(s) Requested	**South County - Program(s) Requested**
☐ Child-Parent Program (0-5yrs)	☐ Child-Parent Program (0-5yrs)
☐ Parent-Child Interaction Therapy (2-7yrs)	☐ Parent-Child Interaction Therapy (2-7yrs)
☐ Child Abuse/Domestic Violence Treatment	☐ Child Abuse Treatment/Domestic Violence Treatment
☐ Great Beginnings Home Visitation (0-5yrs)	☐ Parenting Education
☐ Front Porch (Path_____)	☐ Great Beginnings Home Visitation (0-5yrs)

☐ SafeCare	☐ Front Porch (Path_____) ☐ SafeCare ☐ HOPE ☐ Intensive In-Home Services