NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

LOCAL DEPARTMENT OF SOCIAL SERVICES
REFERRAL FOR A QUALIFIED INDIVIDUAL ASSESSMENT

Directions: This form is to be used as a referral by the local department of social services (LDSS) for all children placed, or recommended for placement, in a Qualified Residential Treatment Program (QRTP) for treatment. This referral form must be completed and emailed to the qualified individual (QI) or QI agency no longer than 24 hours after QRTP placement or recommendation for placement. Note the date of transmission to the QI in a progress note in CONNECTIONS.

QI/AGENCY INFORMATION

Name of QI or QI agency to whom referral is sent:	
Contact name:	Phone number: ( ) -
Date QI received referral: / /	Date QI referral was communicated to LDSS: / /

LDSS INFORMATION

County name:		Date referral sent to QI/agency: / /
Case worker (CW) or case manager (CM) name:	CW or CM phone number: ( ) -	CW or CM email address:
Supervisor's name:	Supervisor's phone number: ( ) -	Supervisor's email address:
Reason for referral:		

Please contact the LDSS for more specific information regarding the **child and family.**

CHILD INFORMATION

Name (First, Last, Middle Initial):	
Date of birth: / /	Gender identification of child:
Location of child at referral:	
Is location a QRTP? ☐ Yes ☐ No If yes, date of placement: / /	

PLACEMENT STATUS

☐ Initial Placement – Article 10 (Abuse/Neglect)
☐ Initial Placement – SSL 384-a (Voluntary Placement)/ 384 SSL (Surrender)
☐ Initial Placement – Article 3 (JD)
☐ Initial Placement – Article 10-C (Destitute Child)
☐ Initial Placement – Article 7 (PINS)
☐ Article 10-B (Replacement)
☐ SSL 404 (Close to Home placement or replacement)

Parent's/Caretaker's name	Parent's phone number: ( ) -
Parent's name:	Parent's phone number: ( ) -