Beyond Empowerment Referral Form

Date of Referral:			
I. Referral Source (choose one):			
Beyond Empowerment Provider:			
☐ Family Counseling Services/ Switchboard	☐ Institute for Child and Family Health	☐ Community Health of South Florida Inc.	
OR			
☐ Department of Juvenile Justice	☐ Law Enforcement	☐ Department of Corrections	☐ Residential Treatment Provider
☐ Miami Dade County Public Schools/ Specify School:_____	☐ Adult/Child Serving Agency/Provider/ Specify: _____	☐ Family Safety Staff	☐ The Youth & Family Center
☐ Our Kids of Miami-Dade and Monroe Inc.	☐ Child Protective Investigator	☐ Private/Public Hospital	☐ Mobile Crisis Team
☐ Crisis Stabilization Unit(s) (CSU)	☐ Self-Referral	☐ Other (Please Specify):	
II. Referral Source Contact Information:			
Name of Referring Person:			
Direct Office Line:		Work Cell Phone Number:	
Email Address:			
How did you hear about Beyond Empowerment?			
Will this be the main point of contact for the participant? ☐ Yes ☐ No			
If you answered "No", who will be the main point of contact? Please provide name and contact information:			
III. Participant Information:			
Name of Participant:			
Current Living Arrangement:			
Address:			
Home Phone Number:		Cell Phone Number:	
Date of Birth:	Age:	Social Security Number:	
Preferred Language: ☐ English ☐ Spanish ☐ Haitian/ Creole ☐ Other (specify):			
Insurance: ☐ None ☐ Applied/ Pending Insurance ☐ Cancelled ☐ Medicaid (specify): ☐ Private (specify): ☐ Other:			
IV. Alternate Contact Information:			
Name:			
Telephone Number(s):			
Relationship:			
Facebook, Instagram, Kik, Etc. Profile Name:			
V. Reason for Referral (please provider additional information to support referral to the Beyond Empowerment Program):			

Approved: 2/4/2015; Revised: 10/5/2015, 2/9/2016, 8/18/2016