Families First Center Referral Form for Court Ordered Supervision

Cause # ______________________________

Petitioner:____________________________ Respondent:__________________________

Contact#: ____________________________ Contact #:___________________________

Address:_____________________________ Address:_____________________________

____________________________________ ____________________________________

Attorney:_____________________________ Attorney:____________________________

Visiting Children: ____

Authorized Visiting Parties: Relationship to children:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Frequency of visits:
___ Weekly
___ Every Other Week
___ Other

Length of visit:
___ One Hour
___ Two Hours
___ Other

Level of Supervision:
___ Therapeutic ($60 per hour, Therapist supervised)
___ Full ($60 per hour, Staff observes and hears all interaction)
___ Intermittent ($45 per hour, Staff enter room about every 10 minutes)
___ Beginning and Ending ($40 per hour, Staff observes greeting and goodbye only)

Responsible for Payment:
___ Custodial Parent
___ Non-Custodial Parent
___ Fee split between the two

Please state your reason for requesting Full level of supervision or any special instructions:

____

If there are any Restraining Orders please attach a copy. ___ Yes No ___

Has this family completed an evaluation with DRCB? ___ Yes No ___

Presiding Judge: ____

NOTE: PLEASE ATTACH A COPY OF THE COURT ORDER TO THIS REFERRAL AND FAX OR MAIL TO:

FAMILIES FIRST CENTER
605 PORTAGE AVENUE
SOUTH BEND, INDIANA 46601
PHONE: 574-287-4375 FAX: 574-288-0691
prose@familiesfirstcenter.org