Mayor's Services Liaison Office
to the Family Court of the District of Columbia

Referral Form

MSLO No. _____
(To be provided by MSLO)

Date Received: _____Referral Source: _____ Phone: _____
Name of Social Worker, Case Worker, Email: _____
ACC, Judicial Officer or Probation Officer
Court Involved___ Court Ordered ___ Information/Referral ___ Judge: _____

Child: _____ Social File/Case No.: _____
(Name)

SS#: _____ D.O.B.: _____ Age: _____

Legal Status: **Committed ____** **Lead Agency: _____**
(Please check) **Not Committed ____** **(Name of Agency)**
Protective Supervision ____

Agency Social Worker or Case Worker: _____
(Name)

_____
(Phone)

_____
(Email)

Child's Current Placement: **Date of Placement: _____**
Foster Care ____ **Kinship Care ____**
Guardianship ____ **Home ____** **Group Home____**
Permanency I ____ **Permanency II ____**

Parent(s)/Caregiver (s) Name: _____

D.O.B: _____ **SS#_____**

Address: _____ Zip: _____ Ward: _____

Phone: _____ (H) _____ (C) _____ (W)_____(Email)

Services *currently* being received by child and/or family:

Substance Abuse

Type of Assistance needed: FTCPP_____ **Drug of Choice_____**

Youth: Out-Patient_____ In-Patient_____ M/F___
Adult: Out-Patient_____ In-Patient_____ M/F___
Gain Q Assessment _____ I/P – O/P_____M/F___

(Office Personnel Only)
Eligible_____
Ineligible_____
Detox Admission Date_____ FTC Admission Date_____
Completion Date (9mo)_____ Completion Date (12mo)_____
Graduation Date_____

Education

Last School of Attendance_____
Current School of Attendance_____
Special Education Yes _____ No_____
General Education Yes _____ No _____
Current/Last Grade_____

Related Family Court Case(s): **Case No.(s)** **Status**
(Neglect, Juvenile, Mental Health, Child Support, Other)

Social or Related Services Issue Area(s) Identified for Interagency Collaboration:

Family	**____**	**Parent Advocacy Groups**	**____**
Medical	**____**	**FUP Application**	**____**
Mental Health	**____**	**RSA**	**____**
Education	**____**	**DDS**	**____**
Social/Community Supports	**____**	**Rapid Housing**	**____**
Substance Abuse	**____**	**Grandparents Program**	**____**
Housing	**____**	**Employment**	**____**
Criminal History	**____**		

Next Hearing Date: _____ **Case No: _____**

__ IH __ Status __ Pre-Adjudication __ Disposition __ Post Disp. __ Other
(Emergency, Show Cause etc.)

Interagency Contacts made by Social Worker or Case Worker to access services:

Name: _____ Agency: _____ Phone: _____
Name: _____ Agency: _____ Phone: _____

Safety-Net Staffing Held **__ Yes __ No __ Not known**
Family Team Meeting Staffing Held **__ Yes __ No __ Not known**

Briefly describe the reason for this referral:

Resolution

(Agency Liaisons only) **(Insert date of action taken)**

Client failed to follow through _____

Client a-waiting services _____

Client obtained services _____

Related Cases Completed _____