Maryland Department of Human Services
Post-Permanency Program

Therapeutic Services Referral Form

Referral Services:	☐Interracial Adoption Support Group ☐Post-Permanency Support Group ☐Post-Permanency Counseling	
Date of Referral:		
Referred By:		
Title:		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
Supervisor Name:		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
Reason for referral:		
Is the child aware of the referral?	☐Yes ☐No	
Is the child's current caregiver aware of the referral?	☐Yes ☐No	

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DEMOGRAPHICS		
Child/Youth's Name:		
Child/Youth's Preferred Name:		
Date of Birth / Age	Date of Birth:	Age:
Preferred Pronouns:	☐He/him ☐She/her ☐ They/them	
Sex:	☐Male ☐Female ☐ Intersex	
Gender Identity:		
Preferred Language:		
Country of Origin:		
Race:	☐African ☐Asian ☐Black/African-American ☐Native Hawaiian ☐Pacific Islander ☐White ☐Not Listed: ____________________________	
Ethnicity:	☐Hispanic ☐Non-Hispanic	
EDUCATION		
School Name:		
Address:		
Phone Number:		
Grade:		
Special Education:	☐Yes ☐No	
IEP Code:	☐Emotional ☐Learning ☐Combined	
504 Plan:	☐Yes ☐No	
Behavioral Concerns in School:	☐Yes ☐No	
History of school suspensions/expulsions:	☐Yes ☐No	
Number of schools attended since Kindergarten: ________		

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508 Kennedy St, NW, Suite 300, Washington DC 20011 | P: 202-526-4802 F: 202-526-4803

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PRIOR PLACEMENT INFORMATION	
Reason for Child Welfare Involvement: (Check all that apply.)	Abuse: ☐Emotional ☐Physical ☐Sexual Neglect: ☐Physical ☐Medical ☐Educational ☐Abandonment ☐Other (explain):
Year of placement in child welfare:	Click or tap to enter a date.
Prior Guardianship/ Adoption/Placement Disruption?	☐Yes ☐No If yes, please explain:
CURRRENT PLACEMENT INFORMATION	
Is this an open adoption?	☐Yes ☐No
Does the child visit Birth Mother?	☐Yes ☐No How often? ___________________________________ Supervised: ☐Yes ☐No
Does the child visit Birth Father?	☐Yes ☐No How often? ___________________________________ Supervised: ☐Yes ☐No
Does the child visit with Siblings?	☐Yes ☐No How often? ___________________________________ Supervised: ☐Yes ☐No

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Contact with other family members?	☐Yes ☐No How often? ____________________________________ Supervised: ☐Yes ☐No Describe with whom and relationship:		
Birth parent's impact on adoption:			
FAMILY INFORMATION			
Parent 1 Name:			
Address:			
Phone Number(s)	Cell:	Home:	Work:
Parent 2 Name:			
Address:	☐Same as Parent 1		
Phone Number(s)	Cell:	Home:	Work:
Date of Placement:	Click or tap to enter a date.		
Date of Adoption Finalization:	Click or tap to enter a date.		
THERAPEUTIC SERVICES			
Is the child currently receiving individual counseling?	☐Yes ☐No How often? Provider (Name, Agency, Address, Phone Number):		
Is yes, what are the issues being addressed?			
Does the current provider know about this referral?	☐Yes ☐No If no, please explain:		

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Is the child and their family receiving family therapy?	☐Yes ☐No How often? ______________________________ Provider (Name, Agency, Address, Phone Number):
Which family?	☐Biological Parents Guardianship Parents Foster Parents ☐Pre-Adoptive Parents ☐Adoptive Parents
If yes, what are the issues being addressed?	
Does the current provider know about this referral?	☐Yes ☐No If no, please explain:
Has or is the child participating in any support groups?	☐Yes ☐No How often? _________________________________ Date of participation: _________________________ Provider (Name, Agency, Address, Phone Number):
Has or is the child's family participating in a support group?	☐Yes ☐No How often? ________________________________ Date of participation: ________________________ Provider (Name, Agency, Address, Phone Number):

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PROFESSIONALS		
Foster Care Social Worker:		
Agency:		
Address:		
Phone Number (s)	Cell:	Work:
Email Address:		
Supervisor Name:		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
Adoption Social Worker:		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
Supervisor Name:		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
Guardian Ad Litem:		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
Judge:		
Address:		
Phone Number:	Cell:	Work:
Email:		
Court Appointed Special Advocate:		
Address:		
Phone Number:	Cell:	Work:
Email:		

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Attachments (check what is included in referral)	
Current Social Summary	☐Yes ☐No
Bonding/Attachment Study	☐Yes ☐No
Most Recent Court Order	☐Yes ☐No
Most recent Court Report	☐Yes ☐No
Psychological	☐Yes ☐No
Psychiatric	☐Yes ☐No

Referring Caseworker Signature: ____

Supervisory Social Worker Signature: _______________________________________

Please submit completed referral and attachments to:

Melanie Geddings-Hayes, LCSW-C Director of Clinical Services
MD_DHHS_Referrals@familyworkstogether.org, 202-629-0204 (office), 202-526-4803 (fax)