New Hope Services, Inc.

Child Advocacy & Parental Support (CAPS) Referral

Please fax completed referrals to: Attn: Rosie Morehous (812) 284-5335

CAPS is a voluntary home-based case management service free to families with children 0-17 years of age who are not otherwise receiving preventative case management services. It provides short term goal oriented services to help families meet their maximum self-sufficiency potential. By connecting families with resources needed to strengthen them, as well as educating them on things such as parenting techniques, we hope to decrease the prevalence of child abuse and neglect in our communities. For questions or concerns, contact the Program Coordinator, **Rosie Morehous at 812-288-4304 ext, 328**

Please provide the information below with detail for families being referred to the program for assistance.

Client (adult) Name(s):____

Address:____________________________ City/Zip code:___________________ County:___________

Client's Primary Phone #: (____) _______________ Secondary Phone #: (___) _________________

Referring Agency/School:____________________ Agency/School Contact:______________________

Agency/School Phone #: (____) _______________ E-mail(optional)____________________________

Special Considerations (Check all that apply and provide detail for items checked "yes" where applicable):

☐Spanish-speaking only
☐Parenting Needs
☐Family is involved with Juvenile Probation, Child Protective Services, or Healthy Families.
☐Family is currently receiving case management services.

1. Are the children in the home with-in target age group of 0-14?
   ☐ Yes ☐ No* (If no, what ages?_________________________________)
2. Do family members have mental health concerns?
   - Children— ☐ Yes ☐ No ____________________
   - Adults— ☐ Yes ☐ No ____________________
3. Do family members abuse alcohol or other substances?
   - Children— ☐ Yes ☐ No ____________________
   - Adults— ☐ Yes ☐ No ____________________
4. Is domestic violence present / suspected in the home? (Circle all applicable)
   ☐ Yes ☐ No ____________________
5. Do family members suffer from health concerns?
   - Children— ☐ Yes ☐ No ____________________
   - Adults— ☐ Yes ☐ No ____________________
6. Do family members have a physical / mental / emotional / developmental disability? (Circle all applicable)
   - Children— ☐ Yes ☐ No ____________________
   - Adults— ☐ Yes ☐ No ____________________
7. Are there behavior concerns for the children—
   - –in the home? ☐ Yes ☐ No ____________________
   - –at school? ☐ Yes ☐ No ____________________
8. Are there problems in school for the children with—
   - – grades? ☐ Yes ☐ No ____________________
   - –attendance? ☐ Yes ☐ No ____________________
9. Would the family benefit financially with budget and resource referrals?
   ☐ Yes ☐ No ____________________
10. Do the Clients being referred have legal custody of the children in need of CAPS services?
    ☐ Yes ☐ No* ____________________
    (please explain circumstance.)
11. Is the family aware of, and in agreement to, this CAPS referral?
    ☐ Yes ☐ No ____________________

Other concerns:____