



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



**Child Welfare Referral for Substance Abuse
Assessment and Treatment Services**

To: _____ Date: _____

Reply to: _____
Referring CW/CHBS worker

Address: _____
Office location

Child Welfare (CW) or Comprehensive Home Based Services (CHBS) worker, as applicable, completes this form to refer clients who are in need of substance abuse assessment, treatment services, or both.

Identifying information.

Case name			County		KK number
Family street address	City	State	Zip	Area code	Phone

Family members referred for services.

First name, MI, last name	Date of birth	Gender	Race

Eligibility.

The income and resources are insufficient to meet the need for services

Reason for referral. Specify need for substance abuse assessment, treatment services, or both.

Referring CW/CHBS worker signature		Date
E-mail address	Area code	Work phone
CW/CHBS supervisor signature		Date

Routing: Original - Send with Form 04MP025E (DCFS-75), Voluntary Family Service Agreement, 04KI008E (CWS-KIDS-10), Treatment Plan, or 04KI012E (CWS-KIDS-24), Individualized Service Plan (ISP), as applicable to provider; and
Copy - Client and case record.