# Center for Family & Child and Enrichment, Inc.

**BNet Referral Form**

Any child referred to BNet must:

Be a Florida KidCare Title XXI recipient; no other insurance is accepted

Be between the ages of 5 years old and not yet 19 years old

# REFERRAL INFORMATION

Date of Referral:

**Referral Source:**  Self-Referral  Parent  School  Department of Juvenile Justice  DCF  Physician  other **Referred By** (*Name*): **Relationship to Client**: **Phone #: Email Address:**

# GENERAL INFORMATION

Child’s First Name: Child’s Last Name: DOB: Social Security: Gender:  Male  Female Preferred Language: Address: Apt: City: Zip Code: Work #: Cell #:

**School:** Grade:

**The client or legal guardian is deaf or hard of hearing:**  No  Yes – Specify: **The client has other known disabilities:**  No  Yes – Specify: \_ **Special accommodations needed:**  No  Yes – Specify:

# PROGRAM ELIGIBILITY

Please check all that apply:

|  |
| --- |
| * Child does not have a primary diagnosis of ADHD |
| * Family is willing to participate in all treatment services |
| * Primary diagnosis of Mental Health or Co-occurring disorder |

# REASON FOR REFERRAL

**FAMILY/PLACEMENT**

Parent/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Client: Address: Apt: City: Zip Code: Work: Cell:

# Please use one of the following options to submit the referral:

|  |  |  |
| --- | --- | --- |
| Fax: 305-623-7893 | E-mail: ggomez[@cfceinc.org](mailto:Referrals@icfhinc.org) | Phone: 305-62-7450 Ext.1749 |