

St. Cloud Area Family YMCA Visitation/Exchange Professional Referral

Date: _____

Case Name:

County:

Case Worker:

Case Worker Phone Number:

Case Worker Email:

Case Worker Fax:

Service Requested:

- ☐ Supervised Visitation for Parent(s)
- ☐ Supervised Visitation with Parent Coaching
- ☐ Sibling Visitation (Siblings only, no parents)
- ☐ Supervised Exchanges
- ☐ Transitional Visitation (Supervisor checks in on family periodically)
- ☐ In-Home Visitation
 - Where?
 - Has this location been vetted by the referral source? ☐ Yes ☐ No
- ☐ Off-Site Visitation (Location up to 40 miles from St. Cloud)
 - Where?
- ☐ Virtual Visitations (15 or 30 minute increments via Zoom)

Primary Reason for Child Protection Involvement (Mark all that Apply):

- ☐ Physical Abuse (by whom?):
- ☐ Sexual Abuse (by whom?):
- ☐ Neglect (indicate specific type of neglect):
- ☐ Chemical Dependency (drug of choice?):
- ☐ Other:

Supervised Visitation is with:

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Grandparent/s | <input type="checkbox"/> Other (Specify): | |

Exchanges are Between (Check all that Apply):

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Grandparent/s | <input type="checkbox"/> Foster Parent(s) | |

Visiting Parent(s) Information:

Name: _____	Date of Birth: _____
Home: _____	Cell: _____
Email: _____	Address: _____

Name: _____	Date of Birth: _____
Home: _____	Cell: _____
Email: _____	Address: _____

Placement Information (Who the Child/ren are Residing with):

Name: _____	Relation: _____
DOB: _____	Email: _____
Cell: _____	Home: _____
Address: _____	

Name: _____	Relation: _____
DOB: _____	Email: _____
Cell: _____	Home: _____
Address: _____	

Name: _____	Relation: _____
DOB: _____	Email: _____
Cell: _____	Home: _____
Address: _____	

Child/ren Information:

	Name	Gender	Date of Birth	Health Concerns
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

Who will be transporting the child/ren to visitation/exchanges? _____

(If transporter is not listed in 'Placement Information', please provide date of birth)

Are other visitors allowed? ☐ No ☐ Yes, Who: _____ DOB: _____

Swimming can be done during the visitation: ☐ No ☐ Yes

Photographs can be taken? ☐ No ☐ Yes With a cell phone: ☐ No ☐ Yes

15-Minute rule between parties to ensure no contact during pick-up/drop-off times?

☐ No ☐ Yes

Rock climbing can be done during the visitation: ☐ No ☐ Yes, Release Signer: _____

Is there a protection order (OFP/HRO/DANCO) in place regarding the involved parties or child/ren?

☐ No ☐ Yes, for whom? Please provide brief details. _____

Are there any behaviors to be aware of? _____

Additional Safety Concerns or information:

Visit Frequency Requested:

Per Week: _____

Length (4 hour Max): _____

Exchange Frequency Requested:

Intended Pick-Up Day/Time: _____

Intended Return Day/Time: _____

Please include the following forms/documents in addition to this completed referral form, and send to: **Heidi.theobald@scymca.org**

- ☐ Completed Referral Form
- ☐ Court Order
- ☐ Release of Information