INSTITUTE FOR BLACK JUSTICE

Family Advocacy Referral Form

Thank you for referring your client to the IBJ CHIMES Program. The goal of IBJ CHIMES is to remove barriers to reunification through advocacy, teamwork, and efficient distribution of the IBJ's economic resources. CHIMES program participatns must have a current case or recent history of involvement with the child welfare system, be a recent survivor of domestic violence, or be income-constrained and in need of family advocacy resources.

You may find more details about the CHIMES Program at
www.instituteforblackjustice.org
Our phone number for new referrals is (253)325-3530

For more information about this program, talk to your FCAP evaluator or call the FCAP Coordinator at (206) 744-1600

A.

IBJ CHIMES Advocacy & Reunification Services	IBJ CHIMES Reunification Grant Program	IBJ CHIMES Civil Legal Services Grant Program
☐	☐	☐
Attach client-signed DCYF ROI Form	*Financial eligibility required*	*Domestic Violence Survivors*

B. CLIENT AND CHILD/REN INFORMATION:

Client's Name: _____ Phone: _____

Client's Email: _____ Cell Phone: _____

Client's Address: _____

City, State, Zip: _____

Active or Recent CPS Action or Dependency? ☐ YES ☐ NO

IF YES, CASE INFORMATION REQUIRED:

Case File Numbers: _____

Washington State County where case is filed: _____

Child's Name: _____ Date of Birth: (MM-DD-YYYY) _____

Child's Name: _____ Date of Birth: (MM-DD-YYYY) _____

Child's Name: _____ Date of Birth: (MM-DD-YYYY) _____

Tribal Affiliation: ☐ YES ☐ NO

IF YES, NAME OF TRIBE: _____

DCYF Social worker: _____ Phone: _____

Social worker Email: _____

Supervisor's Name: _____ Phone: _____

C.

Current Caregiver Name: _____

Caregiver Address: _____

_____

Caregiver Phone Number: _____

Caregiver Email Address: _____

☐ Foster Care

☐ Group Care

☐ Relative

☐ Pre-Adoptive Home

☐ Other (Specify) _____

D. Legal Services Provider Information

Primary Service Providers (last six months)

Please identify the primary service providers for the child, caregivers or family

Attorney Name: _____ _____

Phone: _____ _____

Agency: _____ **Email:** _____

Social Worker: _____ **Phone:** _____

Agency: _____ **Email:** _____

Attorney Name: _____ _____

Phone: _____ _____

Agency: _____ **Email:** _____

Social Worker: _____ **Phone:** _____

Agency: _____ **Email:** _____

E. Attach Required Documents *(Most Recent)*

- ☐ DCYF Release of Information (*Signed by client*)
- ☐ Dependency Review Court Order
- ☐ Attorney Release of Information (*Signed by client*)
- ☐ Safety Plan
- ☐ Court Orders

APPROVED FOR:

☐ **ADVOCACY** ☐ **R.G.** (*REUNIFICATION GRANT*) ☐ **L.G.** (*LEGAL SERVICES GRANT*)

☐ **NOT APPROVED** ☐ **APPLICATION INCOMPLETE** **MISSING:** _____

ASSIGNED SOCIAL WORKER: _____

ASSIGNED VOLUNTEER(S): _____ _____