ADOPTION SERVICES REFERRAL FORM

Please select the type of service for your referral

- ☐ Child-Focused Recruitment (adoption goal)
- ☐ Finalization Assistance

Child's Information

First _____ Middle _____ Last _____
Date of Birth _____ Gender _____ Race _____
OASIS Client ID# _____ (*required information*, 7 or 8 digits, found on placement history)
Date entered foster care _____
Does the child have TPR? _____ Date(s) of TPR _____

***If this child has siblings in the same placement, please use the supplemental page to include their information. If siblings are in separate placements, please complete a full referral form for each.*

Current Placement (please list name of family or facility):

- ☐ Adoptive _____
- ☐ Foster _____
- ☐ Group Home _____
- ☐ Residential _____

Address _____
Email Address of best contact _____
Phone Number _____

Referring DSS Agency _____
Primary Worker _____ Phone _____
Email _____

PLEASE SEE PAGE 2

If you are requesting **finalization assistance, please answer the following questions:

Do you need help with the full disclosure? _____
Do you need help with the Report of Investigation? _____
What attorney will be assigned this case? _____

If this is a **recruitment referral, please answer the following questions:

Have there been recruitment efforts in the past? _____
Has the child had a disrupted or dissolved adoption in the past? _____
Approximately how many placements has the child had? _____

Needs and/or conditions (please check any that apply):

- ☐ Medically fragile or other significant medical needs
- ☐ Autism Spectrum
- ☐ Intellectual Disability
- ☐ Educational challenges and/or IEP
- ☐ Alternative School placement
- ☐ Diagnosis of Reactive Attachment Disorder
- ☐ History of (or current) residential placement
- ☐ Physical aggression towards children or adults
- ☐ History of destruction of property
- ☐ Sexualized behaviors, promiscuity, perpetrating
- ☐ Running away / AWOL behaviors
- ☐ Concerning behavior around animals
- ☐ Past or pending charges
- ☐ Other: _____

Release of Information:

I do hereby allow Children's Home Society of Virginia (CHSVA) to submit and use photo representation of the child named on this referral for service, promotional and recruitment purposes (including the CHS website) without limitation unless otherwise noted. I also hereby authorize the release of pertinent and confidential information found in the youth's case record to CHSVA. By way of example, but not limited to: foster care plans, treatment plans, social histories, psychological evaluations, medical records, birth family information and placement history.

Signature _____ Date of Referral_____

Please email this form to adoption@chsva.org.

children's home society OF VIRGINIA

SUPPLEMENTAL PAGE FOR SIBLING INFORMATION

Please only complete this page if siblings are to be adopted in the same home.

Sibling

First ________________________ Middle __________________ Last _____________________________
Date of Birth __________________ Gender _______________ Race _____________________________
OASIS Client ID# __________________________ Date entered care _____________________________
Does the child have TPR? ___________ Date(s) of TPR ______________________________________

Sibling

First ________________________ Middle __________________ Last _____________________________
Date of Birth __________________ Gender _______________ Race _____________________________
OASIS Client ID# __________________________ Date entered care _____________________________
Does the child have TPR? ___________ Date(s) of TPR ______________________________________

Sibling

First ________________________ Middle __________________ Last _____________________________
Date of Birth __________________ Gender _______________ Race _____________________________
OASIS Client ID# __________________________ Date entered care _____________________________
Does the child have TPR? ___________ Date(s) of TPR ______________________________________

Sibling

First ________________________ Middle __________________ Last _____________________________
Date of Birth __________________ Gender _______________ Race _____________________________
OASIS Client ID# __________________________ Date entered care _____________________________
Does the child have TPR? ___________ Date(s) of TPR ______________________________________

Sibling

First ________________________ Middle __________________ Last _____________________________
Date of Birth __________________ Gender _______________ Race _____________________________
OASIS Client ID# __________________________ Date entered care _____________________________
Does the child have TPR? ___________ Date(s) of TPR ______________________________________