THE FAMILY INCLUSION NETWORK OF WESTERN AUSTRALIA INC.

REQUEST FOR ASSISTANCE FORM

The Family Inclusion Network of WA provides services for parents or family members with children in care or at risk of being placed in care. If you require services or you have a client you want to refer, please complete this form.

FAMILY DETAILS	
Surname:	Telephone:
First Name:	Mobile:
Address/Postal Address:	Email:
	Ethnicity: ***(Optional)***
Post Code:	Religion: ***(Optional)***

Were you a child raised in care? [ ] Yes [ ] No
Do you have a disability? [ ] Yes [ ] No
Do you have other supports? [ ] Yes [ ] No

Please list the names of children, their DOB, and what Care & Protection orders are in place *(if any)*:
(Please include children's surname if different from your own) (Orders can be Interim, Supervision, 2 year or 18 years)

Name:	*DOB:*	*Order in Place:*
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Name:	*DOB:*	*Order in Place:*

REFERRAL SOURCE

Who is making this referral? Name: :

[ ] Self Referral
Where did you hear about us?.....

[ ] Family or Friend	[ ] Health worker (e.g., hospital, GP, Child Health Nurse, Mental Health
[ ] CPFS (eg. Case Worker, Child Advocate)	[ ] Community Services or Agency
[ ] Other Government Dept (eg. Prison, Centrelink, Other)	[ ] Other (specify):

Reason for assistance?

CPFS office the case is open to:	**Case Manager Name:**
Team Leader:	**Legal Representative:** [ ] Yes [ ] No

Would you like information/brochures about Fin WA sent to you? [ ] Yes [ ] No

OFFICE USE ONLY
Date Received: : _____
Phone Advice Only ☐ Time Taken:_____
Request for Assistance ☐
Immediate Response Provided: Y/N By: _____On: _____ Purpose: _____
Case Allocated to: _____ On: _____

The Family Inclusion Network of Western Australia Inc.
156 Vincent St, North Perth, WA 6006 PO Box 140 North Perth, WA 6906
T: 08-9328 6434 F: 08-9227 9052 E: info@finwa.org.au W: www.finwa.org.au