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|  | **SUD Residential Referral Form**This authorization is valid for up to 180 days from the date of this referral | **DATE OF REFERRAL** |

|  |  |  |  |
| --- | --- | --- | --- |
| Starting Date (*Child enrolled at facility)* |       | Parent Name |       |
| Provider Name |    | FAMLINK Provider ID # |  |
| DCYF Caseworker |    | DCYF Caseworker Phone # |  |
| DCYF Office  |  | FAMLINK Case ID # |  |
| Child Name (*First and Last Name)* |    | Client Phone # *(For children also give the caregiver’s phone number )* |  |
| Child Person FAMLINK ID |  | Child DOB: |  |
| Date PCA began |  |  |  |

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| --- |
| **Comments** |
| Parent |  |
| Child |  |

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|  **PLEASE SEND PCA VERIFICATION TO INBOX LISTED BELOW** |

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|  |  |       |  |       |
| Social Worker Signature |  | Print Name |  | Date |
|  |  |       |  |       |
| Supervisor Signature |  | Print Name |  | Date |
|  |  |       |  |       |
| Area Administrator Signature |  | Print Name |  | Date |

SUD Residential Court Order Enrollment Doc (DCYF) <dcyf.sudresidentialcourtorderenrollmentdoc@dcyf.wa.gov>