Washington State Department of
CHILDREN, YOUTH & FAMILIES

# SUD Residential Referral Form

This authorization is valid for up to 180 days from the date of this referral

| DATE OF REFERRAL |
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| 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 | | | |

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

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

| | | |
| --- | --- | --- |
| 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>