Georgia Department of Human Services

INTERAGENCY/INTEROFFICE REFERRAL AND FOLLOW-UP

Grandparents Raising Grandchildren (GrG)

DATE: ___/___/____

TO:
- ☐ Division of Family and Children Services
- ☐ Division of Aging Services
- ☐ AAA
- ☐ Division of Child Support Services
- ☐ Department of Public Health
- ☐ Department of BMHDD
- ☐ Department of Education
- ☐ Relative Caregiver Hotline (Legal Services)

County:

From:
- ☐ Division of Family and Children Services
- ☐ Division of Aging Services
- ☐ AAA
- ☐ Division of Child Support Services
- ☐ Department of Public Health
- ☐ Department of BMHDD
- ☐ Department of Education
- ☐ Relative Caregiver Hotline (Legal Services)

County:

ATTN:

BY:

RE:

GrG Name (First, Middle, Maiden, Last)

Address (Number, Street-Route-P.O. Box) Apt. No.

CITY STATE ZIP CODE COUNTY TELEPHONE – Home Telephone – Other

Gender: ☐ M ☐ F DOB: / / RACE SOC. SEC. NO.: - -

Language (if other than English):

Division of Aging Services

- ☐ Caregiving, including GrG.
- ☐ Elder Rights and Advocacy Programs
- ☐ Long Term Care Ombudsman
- ☐ Georgia Cares
- ☐ Community Care Services Program
- ☐ Home and Community Based
- ☐ AAA Information & Assistance Services
- ☐ Wellness Programs
- ☐ Senior Centers
- ☐ Home Delivered Meals

Adult Protective Services: **DO NOT USE 713G**, **Call 1-888-774-0152** to report instances of abuse, neglect or exploitation of disabled adults or elder persons (**who are NOT residents of nursing homes or personal care homes)**

CHILD SUPPORT (**NOTE**: Complete Page 2)

☐ Medical support for child ☐ Payment Redirect

Division of Family and Children's Services

OFI ☐ TANF (review for enhanced services) ☐ Food Stamps ☐ Medicaid ☐ Child Care ☐ Energy Assistance ☐ Refugee Assistance

Social Services ☐ Adoption Services ☐ ICPC ☐ Foster Care ☐ Child Protective Services ☐ Relative Care Subsidy ☐ Subsidized Guardianship ☐ Relative Foster Care ☐ Enhanced Relative Rate

Department of Public Health Referral Services requested for ☐Grandparent, ☐child or ☐both.

Services
- ☐ Child Health
- ☐ Adolescent Health
- ☐ Prenatal Services
- ☐ Family Planning
- ☐ Immunizations
- ☐ Birth or Death Certificates
- ☐ Oral Health
- ☐ WIC
- ☐ STD/HIV
- ☐ Adult Health

Department of Behavioral Health and Developmental Disabilities

To refer for services, call 1- 800-715-4225 AND forward 713G to MHGRG@dhr.state.ga.us

FOLLOW-UP COMMENTS

☐ Referral accepted ☐ Incorrect referral ☐ Referred to: ____ ☐ Unable to contact Grandparent

REASON FOR REFERRAL:

REPLY TO:
NAME:
AGENCY:
E-MAIL ADDRESS:

PLEASE REPLY TO REFERRAL SOURCE WITHIN FIVE (5) BUSINESS DAYS.

If referring to DCSS: complete page 2 in its entirety

If referring to DBHDD: next section must be completed

If referring to DFCS, DAS/AAA or DPH: next section is optional

NAME OF CHILD(REN):

_____ ☐ M ☐ F; Race: _____DOB: _____/__/____ SSN:_____ Medicaid/SUCCESS ID: _____

_____ ☐ M ☐ F; Race: _____ DOB: _____/__/____ SSN:_____ Medicaid/SUCCESS ID: _____

_____ ☐ M ☐ F; Race: _____ DOB: _____/__/____ SSN:_____ Medicaid/SUCCESS ID: _____

Race: Asian; American Indian/Alaska Native; Black or African American; Multi-Racial; Native Hawaiian/Pacific Islander; Unknown; White

***Please note*: For DCSS Referrals:**

If the mother has children by different fathers, list only the children of one (1) father per referral form.

Complete sections below ONLY IF referring to OCSS:

Division of Child Support Services

Grandparents Intervention Referral Form

☐ **IV-B MEDICAID (Foster Care Medicaid)**
☐ **IV-B NON- MEDICAID (Adoption Assistance)**
☐ **IV-E (Foster Care)**
☐ **No Services**
(No application fee is required.)

Referral Source: ☐ **Aging** ☐ **DFCS** ☐ **RevMax Center** **Phone Number:**

Referring Party: **Fax Number:**

Name of Mother:

Name:_____ Race: _SSN: _____ DOB:__/__/____

_____
Mother's Address

_____
Mother's Employer (Last Known) and Work Address

Name of ☐ **Legal Father** ☐ **Putative Father** **Father Is Receiving (check all that apply):** ☐ **TANF;** ☐ **SSI**

Name:_____ Race: _SSN: _____ DOB: __/__/____

_____
Father's Address ***(If Different than Mother)***

_____
Father's Employer (Last Known) and Work Address

Grandparent Guardian*:* _____

Grandparent's Address: _____

Phone Number: _____ Race: _SSN: _____ DOB:__/__/____

***IMPORTANT*:**

Has Paternity Been Established? ☐ Yes ☐ No If yes, how?_____

Parents Are: ☐ Married; ☐ Never Married; ☐ Separated; ☐ Divorced

Parent(s) Receiving Adoption Assistance Payments? ☐ Yes Amount? $_____ Paid to Whom? _____

Has child support been ordered in the juvenile court? ☐ Yes ☐ No If YES, attach a copy of the order for DCSS.

If child support was ordered in another court of competent jurisdiction, specify the type of order and **attach a copy**, if available.
☐ DCSS order ☐ Divorce order Order issued in _____ County, State of _____
☐ Medicaid eligibility determination is "pending".
COMMENTS_____.