

**THE INSTITUTE FOR FAMILY ENRICHMENT**  
**KEY CONTACTS**

Child's Name: \_\_\_\_\_ CR/ID #: \_\_\_\_\_ TIFFE Case #: \_\_\_\_\_  
 Admission Date: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 \_\_\_\_\_  
 Parent(s)/Guardian(s): \_\_\_\_\_

SERVICE	NAME	AGENCY/ADDRESS	PHONE	FAX
<b>DOH-CAMHD 13101 or Assessment &amp; Outpatient Services (please circle)</b>				
QMHP / MHP				
Paraprofessional				
DOH-CC				
<b>DOE INTENSIVE / EIS (please circle)</b>				
IISC / AC				
ST				
SSC				
IEP / Care Coordinator				
<b>DOE Psychiatric / Assessment Services (please circle)</b>				
Psychiatrist				
Psychologist				
<b>Other Contacts</b>				
Probation				
Guardian Ad Litem				
DHS				
Medical/Dental				
Recreational				
Social				

**List Dates Log Completed or Updated:** \_\_\_\_\_