

Youth Service Bureau of the Illinois Valley/Hope House
Supervised Visitation & Safe Exchange Services
417 W. Madison Street, Suite 205 B
Ottawa, IL 61350
Phone 815-431-0080
Fax 815-431-0080

SUPERVISED VISITATION OR EXCHANGE REFERRAL FORM

Date: _____

Information on Referring Source:

Name of Referring Source _____

Address of Referring Source _____

Contact Person at Referring Source _____

Contact Person's Telephone No. _____

Information on Referral:

** If contact information for either party is confidential, please do not provide this document to any other person (including the parties) or place it in a public file.

Name of Custodial Parent: _____

Address: _____

Telephone: _____

Attorney: _____

Name of Non-Custodial Parent: _____

Address: _____

Telephone: _____

Attorney: _____

Children:

Name	D.O.B.	Age
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1. _____

2. _____

3. _____

4. _____

Service Requested:

Supervised Visitation

Supervised Exchange

Basis for Referral (does not need a court or DCFS finding). *Please check all that apply.*

_____ Visitation is by and between parents

AND

there has been an allegation of

_____ domestic violence _____ sexual violence

_____ stalking _____ child abuse

by the _____ father _____ mother

against the _____ other parent _____ child

Other relevant information:

_____ father _____ mother has failed to comply with court orders

_____ father _____ mother does not speak appropriately with the child(ren)

_____ father _____ mother has been absent from the child(ren)'s life

because: _____

_____ father _____ mother is a flight risk with the child(ren)

_____ father _____ mother abuses substances

There is an Order of Protection against the _____ father _____ mother

Other: _____

Is there any current visitation order? _____ Yes _____ No. If yes, what are the terms?

What, if any, special needs does this family have?

What else should we know?

Please attach any court orders affecting this family (custody/visitation orders, Orders of Protection, criminal case information, etc)