|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Case Name: | | | | | | | Initial Referral | | | Resumption of Services  Resumption of Intensive Services (use only on  cases referred prior to 1/1/20) | | | |
| *Last Name First Name MI* | | | | | | | Tier 1 Services  Tier 2 Services | | | | | | |
| Date of Initial referral: |  | | | Time of Initial Referral: | | |  | | | Date of Resumption of Services: |  | | |
| Address of family: |  | | | | | | | | | | | | |
| City, State, Zip: |  | | | | | | County where family resides: | | | | | | |
| Contact name/number(s) for family: | | | | | | |  | | | | | | |
| Non- residential parent(s): | | Name: | | | | | Address: | | | | Phone: | | |
|  | | Name: | | | | | Address: | | | | Phone: | | |
|  | | Name: | | | | | Address: | | | | Phone: | | |
| FACTS Case #  (When Available): | |  | | | | | CPS Specialist: | | | |  | | |
| Case Name Client ID #: | |  | | | | | CPS Specialist’s Best Contact Number: | | | |  | | |
| Local DCF Office: | |  | | | | | CPS Specialist’s Email: | | | |  | | |
| DCF Region: | |  | | | | | DCF Supervisor: | | | |  | | |
| Referred to Provider Agency: | |  | | | | | DCF Supervisor’s Best Contact Number: | | | |  | | |
| Family Preservation Liaison Assigned? | | No  Yes (*If yes, list name):* | | | | | Family Preservation Liaison Phone Number: | | | |  | | |
| Dates/Times CPS Specialist/Family Preservation Liaison is available for Initial Family Meeting: | | | | | | |  | | | | | | |
| **SECTION I: Additional Family Information** | | | | | | | | | | | | | |
| Case participants: | | | | | | | | | | | | | |
| Date Family Preservation Services accepted? | | | | | | | | | | | | | |
| Date of last contact with family? | | | | | | | Type of contact:  In Person  Phone | | | | | | |
| Are there language barriers?  No  Yes | | | | | | | *Explain*: | | | | | | |
| Has an interpreter been used with this family?  No  Yes *(If yes, list name and number below)* | | | | | | | | | | | | | |
| Name of Interpreter: | | | | | | | Contact Number of Interpreter: | | | | | | |
| Worker Safety Issues: *(Explain)* | | | | | | | | | | | | | |
| Is there a reason to believe that any family member is a member or eligible to be a member of a recognized Tribe, and the Indian Child Welfare Act (ICWA) applies?  No  Yes *(If yes, list Tribal Affiliation):*       *Name of Enrolled Family Member(s):* | | | | | | | | | | | | | |
| **SECTION II: Court Involvement** | | | | | | | | | | | | | |
| Is/are any child(ren) in this family in DCF custody?  No  Yes (*If yes, list names below with date of custody and next court hearing for each)* | | | | | | | | | | | | | |
| Name of Child: | | | | | Date of Custody: | | | | | | Next Court Hearing Date: | | |
| Name of Child: | | | | | Date of Custody: | | | | | | Next Court Hearing Date: | | |
| Name of Child: | | | | | Date of Custody: | | | | | | Next Court Hearing Date: | | |
| Name of Child: | | | | | Date of Custody: | | | | | | Next Court Hearing Date: | | |
| If there is a child(ren) in custody, when is the next custody case plan due? | | | | | | | | | | | | | |
| Is there other court involvement for any of the family members?  No  Yes *(If yes, list names, etc. below)* | | | | | | | | | | | | | |
| Name: | | | | | Date/location of Court Hearing: | | | | | | Type of Court Hearing\*: | | |
| Name: | | | | | Date/location of Court Hearing: | | | | | | Type of Court Hearing\*: | | |
| Name: | | | | | Date/location of Court Hearing: | | | | | | Type of Court Hearing\*: | | |
| \*Types of Court Hearings:  CINC: Temporary Custody, Adjudication, Disposition, Review, Other:  Juvenile Offender: Adjudication, Disposition, Revocation, Other: | | | | | | | | | | | | | |
| \*Types of Adult Court Hearings*:* Family Court/Divorce Custody; Criminal, Other: | | | | | | | | | | | | | |
| Court Case Number(s): | | | | | | | | Judicial District/County or Judge: | | | | | |
| Has the court ordered Family Preservation Services?  No  Yes *(If yes, list court date, case number and court below)* | | | | | | | | | | | | | |
| Next Court Date(s): | | | | | Court Case Number: | | | | | | Judicial District/County or Judge: | | |
|  | | | | |  | | | | | |  | | |
| **Section III: Reason for Referral** | | | | | | | | | | | | |
| **Presenting Problem:**  Abuse  Neglect  Family In Need of Assessment  Pregnant Woman Using Substances  If applicable, check status of child abuse/neglect investigation:  In Process  Unsubstantiated  Affirmed  Substantiated  Is this referral the result of a Juvenile Offender case?  No  Yes  Has the Family Based Assessment (FBA), PPS 2030 series, been completed?  No  Yes | | | | | | | | | | | | |
| **Synopsis of Reasons for Referral:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Safety Concerns: *(List all safety concerns to be addressed below)* | | | | | | | | | | | | |
| Protective Factors to Mitigate Safety Concerns: (*Include family’s strengths, resources and actions taken to help protect children; Appendices 2J, 1B, and/or 2F may be used for guides)* | | | | | | | | | | | | |
| Risk Factors: *(List known risk factors below)* | | | | | | | | | | | | |
| Protective Factors to Mitigate Risk Factors: (*Include family’s strengths, resources and actions taken to help protect children; Appendices 2J, 1B, and/or 2F may be used for guides)* | | | | | | | | | | | | |
| Prior DCF involvement and/or services?  No  Yes If yes, provide details of prior DCF involvement: | | | | | | | | | | | | |
| **Section IV: Service Needs** | | | | | | | | | | | | |
| Is any family member receiving mental health services?  No  Yes (*If yes, complete the* *following:)*  Has any family member received mental health services in the past? | | | | | | | | | | | | |
| Name of Family Member | | | | | | | | | Name of Past/Current Therapist or Case Manager | | | |
|  | | | | | | | | |  | | | |
|  | | | | | | | | |  | | | |
|  | | | | | | | | |  | | | |
|  | | | | | | | | |  | | | |
| Does any family member have suspected or confirmed substance use concerns?  No  Yes (*If yes, complete the* *following:)* | | | | | | | | | | | | |
| Name of Family Member | | | Type of Substance Used | | | | | | Has a drug screen, evaluation, or court confirmed substance use? If yes, when? | | | |
|  | | |  | | | | | |  | | | |
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|  | | |  | | | | | |  | | | |
| Is this a Pregnant Woman Using Substances (PWS)?  No  Yes | | | | | | | | | *(If Yes,* *check if opioids or non-opioids)*  Opioids  Non-Opioids | | | |
| List current services being provided through a Client Purchase Agreement and indicate if authorized by DCF to continue. If there are no services, write “none” in the space below. | | | | | | | | | | | | |
| Service | | | | | | Provider | | | | | | DCF Approved |
|  | | | | | |  | | | | | | Yes  No |
| **Section V: Signatures** | | | | | | | | | | | | |
| Completed by: | | | | | | Date: | | | | | | Time: |
| Supervisor Electronic Signature: | | | | | | Date: | | | | | |  |
| Send the following forms to the Provider (check all that apply):  PPS 1000 PPS Face sheet – Required  PPS 2003 Family Based Safety Plan, if applicable  PPS 2007 Plan of Safe Care per PPM 2050, if applicable  PPS 3050 Family Service/Preservation Plan for Child Not in Custody, if applicable  PPS 3051 Permanency Plan for Child in Custody, if applicable  Note: DCF CPS Specialist shall be available to FPS provider staff for two hours following referral. | | | | | | | | | | | | |

Distribution: 1. Provider Agency File 2. Regional Support Services Program Consultant 3. DCF Case Record

