Family Preservation Referral

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):*	

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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*:
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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?

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

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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

Kansas
Department for Children and Families