

To DCF CPS Specialist:		From Family Preservation Services Provider / Agency	
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Date:		Referral Date:		<input type="checkbox"/> Tier 1	<input type="checkbox"/> Tier 2
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Reason for Submission: (Check the applicable boxes below)

- Initial/Acknowledgment of Referral
- Drug Toxicology Results/Pregnant Woman Using Substances referral to Medicated-Assisted Treatment
- Resumption of Services
- Corrected Copy
- Status Change
- Non-Completion of Case Plan (FACTS code NC01N)
- Closure

SECTION I Case Identifying Information

Case Name:		Client ID #:	
FACTS Case #:		Court Case #:	

SECTION II Acknowledgment of Referral

Date Referral Received by Provider		Time Referral Received by Provider	<input type="checkbox"/> AM <input type="checkbox"/> PM
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SECTION III Provider Staff Identifying Information

Provider Staff Assigned:		Address:	
Worker Phone #:		24-Hour Access Phone #	

SECTION IV Pregnant Woman Using Substances

Infant's Name:		Date of Birth:		Sex:	<input type="checkbox"/> Female <input type="checkbox"/> Male
			<input type="checkbox"/> Not Live Birth		
Race:	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Declined <input type="checkbox"/> Unable to determine				
Ethnicity:	<input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Central or South American <input type="checkbox"/> Other Spanish Cultural Origin <input type="checkbox"/> Unable to determine <input type="checkbox"/> Declined to provide information				
Tribe:	<input type="checkbox"/> Sac & Fox <input type="checkbox"/> Potawatomi <input type="checkbox"/> Kickapoo <input type="checkbox"/> Iowa <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not applicable				

(Complete if PWS Using Non-Opioid Substances) Infant's Drug Toxicology Test Date: <input type="checkbox"/> Not Tested (Opioid Use Only) Results of infant's test: <input type="checkbox"/> Negative for drugs <input type="checkbox"/> Positive for drugs	(Complete if PWS Using Opioids) <input type="checkbox"/> Pregnant Woman Referred to a Medication Assisted Treatment (MAT) program (Opioid Use Only) Date: <input type="checkbox"/> No Reason:
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SECTION V Case Status Change		
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	Date:	Note:
<input type="checkbox"/> Child released from DCF custody		
<input type="checkbox"/> Court venue change (custody only / services transfer to another region)		
<input type="checkbox"/> Family cannot be located / disengaged from services		
<input type="checkbox"/> Family moved out of state		
<input type="checkbox"/> Family placed children out of state		
<input type="checkbox"/> Family refused to continue services		
<input type="checkbox"/> Family placed children with relatives/kin in another region		
<input type="checkbox"/> Family successfully completed services / case conference complete		
<input type="checkbox"/> Other (specify)		

SECTION VI Case Closure/Payment Cessation		
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	Date:	Note:
<input type="checkbox"/> Family did not sign Family Case Plan/Not engaged in services in 30 days		
<input type="checkbox"/> Conclusion of Initial Intensive phase (only use for cases referred prior to 1/1/20)		
<input type="checkbox"/> Conclusion of 12-month case responsibility-(only use for cases referred prior to 1/1/20)		
<input type="checkbox"/> Conclusion of Tier 1 Services		
<input type="checkbox"/> Conclusion of Tier 2 Services		
<input type="checkbox"/> Family refused to continue services		
<input type="checkbox"/> Family Preservation Services ended due to referral for out-of-home placement of child(ren)		
<input type="checkbox"/> Other (specify)		

DISTRIBUTION

According to local procedures, send to:
Regional Support Services Program Consultant
DCF CPS Specialist/Family Preservation Liaison
DCF Payment Unit/eSCRIPTS
DCF FACTS Unit

