|  |
| --- |
| Section I |
| Date: |  | Receiving DCF Office: |  |
| Receiving DCF Program Administrator: |  | Receiving regional Program Consultant or designee: |  |
| Transferring DCF Office: |  | Transferring DCF CPS Specialist:  |  |
| Transferring DCF Program Administrator: |  | Transferring DCF CPS Specialist’s phone number: |  |
| Section II |
| Case Name: |  | FACTS Case #: |  |
| Family Preservation Referral Date: |  | DCF Assessment / Prevention Case Currently Open  | [ ]  Yes[ ]  No |
| Section III |
| **Note:**Attach current case plan. Send case file immediately. This form is to be sent to the:* receiving DCF Assessment/Prevention Program Administrator
* receiving DCF regional Program Consultant or designee
* Family Preservation Provider Program Director
* Family Preservation Provider Therapist/Case Manager
* transferring DCF CPS Specialist
* transferring DCF Assessment/Prevention Program Administrator
 |
| Signature of Transferring Worker: |  |

