

**Family First Prevention Services Referral/Case
 Status**

The following must be true for referral of Family First Prevention Services:

- Prevention Plan Completed
- Child(ren) is identified as a Candidate for Foster Care on Prevention Plan (Exception: child is parenting/pregnant foster youth)

SECTION I: Identifying Information – Completed by CPS Specialist/FC Liaison

Case Head Name:		FACTS Case #:		FACTS Event #:	
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Address of Family: City, State, Zip: County where family resides:	Phone number: Best way to contact family (phone, text, person, other):
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Non-custodial Parent(s) Name: Address: Click or tap here to enter text. City, State, Zip: Click or tap here to enter text.	Phone: Best way to contact family (phone, text, person, other):
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CPS Specialist/Foster Care Liaison: Phone number: CPS/Foster Care Liaison Supervisor: DCF Office (if applicable)/Region/County:	Date of Intake Assignment: Click or tap to enter a date. Date of Referral: Click or tap to enter a date.
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Name of child(ren) receiving Family First services:	Client ID's of children receiving services:	Any child in the family in DCF custody: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name: Is the referral for a pregnant foster youth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name: Is the referral for a parenting foster youth with child not in custody of the Secretary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name:
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Answer the following: Is this referral due to a Juvenile Offender case? Yes No

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SECTION II: Type of Case (Check program and, if applicable, appropriate grantee available in your region)- **Completed by CPS Specialist/FC Liaison**

Kinship Navigator (FK01N)	Mental Health (FM01N)	Parent Skill Building (FI01N)	Substance Use Disorder (FS01N)
<input type="checkbox"/> KINTECH- Kansas Legal Services (NIT)	<input type="checkbox"/> Family Centered Treatment- Saint Francis (FCT)	<input type="checkbox"/> ABC- Project Eagle/ LiveWell (ABC)	<input type="checkbox"/> Adolescent Community Reinforcement Approach, A-CRA-DCCCA (ACR also add MOI) *
<div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>NOTE FOR FACTS STAFF:</p> <p>Codes in parentheses.</p> </div>	<input type="checkbox"/> MST - Multisystemic Therapy- Community Solutions (MST)	<input type="checkbox"/> PAT- KPATA (PAT)	<input type="checkbox"/> Parent Child Assistance Program, PCAP- Kansas Children's Service League (PCA)
	<input type="checkbox"/> Functional Family Therapy-Cornerstones (FFT)	<input type="checkbox"/> HFA - Healthy Families America (HFA)	<input type="checkbox"/> Seeking Safety- Saint Francis (SES)
	<input type="checkbox"/> Parent Child Interaction Therapy (PCI)	<input type="checkbox"/> Great Circle <input type="checkbox"/> Lawrence Douglas County Health Dept/Success by 6 <input type="checkbox"/> Kansas Children's Service League	<p><i>*Motivational Interviewing (MOI) included on A-CRA</i></p>
<input type="checkbox"/> Horizons	<input type="checkbox"/> Family Mentoring- CAPS (NPP)		
<input type="checkbox"/> TFI Family Services	<input type="checkbox"/> Fostering Prevention – FAC (FSP)		

SECTION III: Family First Referral Opening – Completed by CPS Specialist/FC Liaison

Reason for Referral (Describe what brought the family to the attention of the agency, why is the family being referred for specified services, and historical involvement with agency):

Required attachments for Family First Prevention Services:

- A/N referrals; PPS referral, 1000, 2030, B, D and F (include SDM assessments, if applicable)
- FINA referrals; PPS referral, 1000, 2030 E and F (include SDM assessments, if applicable)
- All cases; PPS 4300 Prevention Plan
- All cases; Safety plan, if applicable.

SECTION IV: Timely engagement – Completed by Grantee (Initial assessment and/or review of prevention plan with family to occur within 2 business days of referral)

<p>Name of Grantee:</p>	<p>Referred Service Category:</p> <p><input type="checkbox"/> Kinship Navigator (FK01N) <input type="checkbox"/> Mental Health (FM01N)</p>
<p>Date of Initial contact with Family: <small>Click or tap to enter a date.</small></p>	<p><input type="checkbox"/> Substance Use Disorder (FS01N) <input type="checkbox"/> Parent Skill Building (FI01N)</p>

Name of Grantee Assigned Worker:	Email:	Phone:
Name of Grantee Assigned Supervisor:	Email:	Phone:

SECTION V: Closure of Family First Prevention Services – Completed by Grantee

Name of Grantee: Click or tap here to enter text.	Referred Service Category: <input type="checkbox"/> Kinship Navigator (FK01N) <input type="checkbox"/> Mental Health (FM01N) <input type="checkbox"/> Substance Use Disorder (FS01N) <input type="checkbox"/> Parent Skill Building (FI01N)
Closure Date: Click or tap to enter a date.	

Closure Reason: (Completed by Family First Grantee) Select reason case is closing and provide a summary of the reason for case closure.

- Family has successfully completed services. (Facts Code: CM)
- Retraction within 5 days of referral. (Facts Code: JD)
- Family declined services after 5 days of referral. (Facts Code: CD)
- Family has not addressed the issues/needs identified in the prevention plan. (Facts Code: AD)
- Referral to the Reintegration/Foster Care/Adoption provider. (Facts Code: LD)
- Unable to locate the family or family moved out of provider services area or out of state. (Facts Code: MV)

Closure Summary: (Completed by Family First Grantee)
 Provide a brief description of the family’s progress/functioning at closure, a summary of the reason for closure, or special circumstances leading to closure.

Provide to FACTS Staff, CPS Specialist/FC Liaison, and File

