

FAMILY PRESERVATION REFERRAL AND TRANSMITTAL SHEET

Head of Household:		<input type="checkbox"/> Initial Referral	<input type="checkbox"/> Resumption of Intensive Services
<i>Last Name First Name MI</i>			
Date of Initial referral:		Time of Initial Referral:	Date of Resumption of Intensive services:
Address of family:			
City, State, Zip:			
Contact name/number(s) for family:			
FACTS CASE# (Required):		County where Family resides:	
Casehead Client ID #:		CPS Specialist:	
Local DCF Office:		CPS Specialist's Best Contact Number:	
DCF Region:		CPS Specialist's Email:	
Referred to Provider Agency:		DCF Supervisor and Best Contact Number:	
SECTION I			
ADDITIONAL FAMILY IDENTIFYING INFORMATION:			
Persons(s) in Household Agreeing to Services:			
Date Family Preservation Services accepted?			
Date of last contact with family?		Type of contact: <input type="checkbox"/> In Person <input type="checkbox"/> Phone	
Are there language barriers? <input type="checkbox"/> No <input type="checkbox"/> Yes		Explain:	
Has an interpreter been used with this family? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list name and number below)			
Name of Interpreter:		Contact Number of Interpreter:	
Non-custodial Parent(s):	Name:	Address:	Phone:
Name:	Address:	Phone:	
Name:	Address:	Phone:	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list Tribal Affiliation): Name of Enrolled Family Member:			
SECTION II			
Is/are any child(ren) in this family in DCF custody? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list names below)			
If there is a child in custody, when is the next custody case plan due?			
Is there other court involvement for any of the child(ren)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list names below)			

When is the next court hearing?		Where is the court hearing?
What type of court hearing? <i>(Check below and/or explain)</i>		
<input type="checkbox"/> CINC <i>(if checked, check type):</i> <input type="checkbox"/> Temporary Custody <input type="checkbox"/> Adjudication <input type="checkbox"/> Disposition <input type="checkbox"/> Review <input type="checkbox"/> Permanency <input type="checkbox"/> Other <input type="checkbox"/> Juvenile Offender <i>(if checked, check type):</i> <input type="checkbox"/> Adjudication <input type="checkbox"/> Disposition <input type="checkbox"/> Revocation <input type="checkbox"/> Other <i>(Explain):</i>		
Court Case Number(s):		Judicial District/County or Judge:
Has the court ordered Family Preservation Services? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Is any other family member involved with another type of court? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, explain below)</i>		
Next Court Date(s):	Court Case Number:	Judicial District/County or Judge:

SECTION III

PRESENTING PROBLEM: <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Non-Abuse or Neglect <input type="checkbox"/> Pregnant Woman Using Substances If applicable, give status of child abuse/neglect investigation: <input type="checkbox"/> In Process <input type="checkbox"/> Unsubstantiated <input type="checkbox"/> Affirmed <input type="checkbox"/> Substantiated Is this referral the result of a Juvenile Offender case? <input type="checkbox"/> No <input type="checkbox"/> Yes Has the Family Based Assessment (FBA), PPS 2030 series, been completed? <input type="checkbox"/> No <input type="checkbox"/> Yes
Synopsis of reasons for referral. List all Safety and Risk Factors to be addressed and Child Protective Factors to mitigate concerns below:
Prior DCF involvement and/or services? <input type="checkbox"/> No <input type="checkbox"/> Yes

Has/is any family member received/receiving mental health services? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, complete the following:)</i>		
<u>Name of Family Member</u>	<u>Name of Past/Current Therapist or Case Manager</u>	
Does any family member have suspected or confirmed drug or alcohol issues? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, complete the following:)</i>		
<u>Name of Family Member</u>	<u>Has a UA, Evaluation, or Court confirmed an issue? If yes, when?</u>	
Type of Drugs Used:		
List current services being provided through a Client Purchase Agreement and indicate if authorized by DCF to continue, if any. If there are no services, write "none" in the space below.		
<u>Service</u>	<u>Provider</u>	<u>DCF Approved</u>
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Completed by:	<input type="checkbox"/> Faxed <input type="checkbox"/> E-mailed	Date: / /	Time: :
		<i>(same as referral date)</i>	
Supervisor or Designee Signature: <i>(electronic signature may be used)</i>		Date:	
Send the following forms to the Provider (check all that apply):			
<input type="checkbox"/> PPS – 1000 PPS Face sheet - Required			
<input type="checkbox"/> PPS – 3050 Family Service/Preservation Plan for Child Not in Custody(if applicable)			
<input type="checkbox"/> 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 (No attachments) 3. DCF Case Record

