

State of Kansas Department for Children and Families Prevention and Protection Services	<b>Family Preservation ACKNOWLEDGMENT OF REFERRAL /CHANGE</b>	PPS 5000A REV 10/12 Page 1 of 2
---	---	---------------------------------------

<b>TO DCF Social Worker:</b>		<b>FROM Provider Case Manager/Agency:</b>	
<b>Date:</b>			
<input type="checkbox"/> Initial	<input type="checkbox"/> Reinstatement	<input type="checkbox"/> Corrected Copy	<input type="checkbox"/> Drug Toxicology Results

**SECTION I**

Name of Case Head:	DOB (of case head):		
Client ID #:	FACTS Case #:	Court Case #:	

**SECTION II**

Date Referral Received by Provider:	Time Referral Received by Provider:	<input type="checkbox"/> AM <input type="checkbox"/> PM
-------------------------------------	-------------------------------------	---

**SECTION III**

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

**SECTION IV (Pregnant Woman Using Substances)**

Infants Name:	DOB:	<input type="checkbox"/> Not Live Birth	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Unable to determine <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Declined			
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			
Drug Toxicology Test Date:	Results: <input type="checkbox"/> Negative for drugs		
<input type="checkbox"/> Not Tested	<input type="checkbox"/> Positive for drugs (specify type):		

**SECTION V**

Cessation of Monthly Payment and/or Closure	Date	
<input type="checkbox"/> Released from DCF Custody		
<input type="checkbox"/> Conclusion of Initial Intensive phase		
<input type="checkbox"/> Conclusion of 12 month case responsibility		
<input type="checkbox"/> Venue Change (custody only)		
<input type="checkbox"/> FP services ended due to referral for out-of-home placement		
<input type="checkbox"/> Other (specify)		

**E-mail to:**  
 ① Family Preservation Regional Contract Specialist, ② DCF Social Worker, and ③ DCF Payment Unit, according to local procedures.

