

Section I			
------------------	--	--	--

To: DCF Social Worker		Staff name and Agency	
-----------------------	--	-----------------------	--

Date:	
-------	--

Section II			
-------------------	--	--	--

Case head			
-----------	--	--	--

Case head FACTS no.		Date of Referral	
---------------------	--	------------------	--

Section III			
--------------------	--	--	--

Intensive Phase <input type="checkbox"/>	Non-Intensive phase <input type="checkbox"/>
------------------------------------------	----------------------------------------------

Date Family Last Seen	
-----------------------	--

Section IV			
-------------------	--	--	--

Summary of attempts to locate and case progress: (Please include any new/updated contact information)

Section V			
------------------	--	--	--

Safety Concerns	Yes <input type="checkbox"/>	No <input type="checkbox"/>
-----------------	------------------------------	-----------------------------

If yes, please describe (if there are safety concerns, consider whether a critical incident and/or KPRC report is needed)

Section VI	
-------------------	--

Signature of Provider Staff	
-----------------------------	--

Signature of Provider Supervisor	
----------------------------------	--

