Initial Referral to Out of Home Placement Provider For Child in DCF Custody

SECTION I: Note: This is a Change of Venue ☐ This was an open Family Preservation case ☐.

Child's Name: _____ **Child's DOB** _____ ☐ **Male** ☐ **Female**

Referral to: ☐ R/FC ☐ Reinstatement Date Referred: _____ Time Referred: _____ ☐ AM ☐ PM

Referring CPS Specialist: _____ County: _____ Region: _____

Address: _____ Phone: _____

Email address: _____

Monitoring/Liaison worker: _____ Phone _____

Address : _____

Child's Race _____ Does ICWA Apply? ☐ Yes ☐ No If ICWA applies, has tribe been contacted? ☐ Yes ☐ No Name of Tribe: _____

Child's Ethnicity (per instructions): _____ Court Case # _____

Name of Removal Parent/Caregiver: _____ Address: _____

Phone : _____ ☐ Home ☐ Work Phone : _____ ☐ Home ☐ Work

Mother's name (if different from above): Father's name (if different from above):

Mother's address (if different from above): Father's address (if different from above):

Mother's DOB: Father's DOB:

Mother's Client ID#: Father's Client ID #:

How Father Verified:

If mother deceased, date: If father deceased, date:

Was mother married at time of child's birth? ☐ yes ☐ no ☐ Unable to determine

If unable to determine, list reason:

Is the mother incarcerated? ☐ yes ☐ no

Is the father incarcerated? ☐ yes ☐ no

SECTION II

Child FACTS Client ID #		FACTS Case #		FACTS Event #		Child KEES Client ID#	

Current location of child: _____

Name: _____ Relationship: _____ Phone _____

Did DCF request the petition for removal? ☐ yes ☐ no

Is the referral due to Juvenile Offender case? ☐ yes ☐ no

Primary Reason for Removal/ Reason child was determined unsafe & may differ from assignment (from list below):

Secondary Reason for Removal (from list below-if applicable):

ABUSE	NEGLECT	Family in Need of Assessment FINA	
☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Human Trafficking- Sex ☐ Human Trafficking- Labor	☐ Physical Neglect ☐ Medical Neglect ☐ Lack of Supervision ☐ Abandonment ☐ Educational Neglect ☐ Substance Affected Infant	☐ Child's Alcohol Abuse ☐ Child's Behavior Problem ☐ Child's Disability ☐ Child's Substance Use (Excludes Alcohol-report as Child Alcohol Abuse) ☐ Death of Parent ☐ Inadequate Housing ☐ Infant Positive for Substances ☐ Parent Alcohol Abuse	☐ Parent Substance Use (Note: If using alcohol, opioids or meth, select those specific codes) ☐ Parent's Incarceration ☐ Parent Meth Use ☐ Parent Opioid Use ☐ Caregiver Unable/Unavailable to Provide Care ☐ Relinquishment by parent ☐ Runaway ☐ Truancy

Briefly describe why the child is referred for out of home placement:

Additional information (risk factors identified, status of investigation, follow-up, etc.):

Is it appropriate for this child to attend the initial team meeting? ☐ Yes ☐ No

Reason:

SECTION III: *Siblings*

Sibling names and locations. For siblings in the home, list dates of birth and client ID number.

Name:		DOB:		Client ID#:		Location:	
Name:		DOB:		Client ID#:		Location:	
Name:		DOB:		Client ID#:		Location:	
Name:		DOB:		Client ID#:		Location:	
Name:		DOB:		Client ID#:		Location:	

If a sibling is in custody placed at home, note that and provide information*. Also, recommendations for placement together and/or sibling visitation with referred child. If not recommending placement together and/or sibling visitation, specify why*

SECTION IV: *Important Connections to be maintained for the child. (Include name, type of connection, and contact information.)*

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SECTION V ***School Information***

Current School: _____ Current Grade: _____

Address: _____ School District _____

Current Educational Needs: ☐ Reg. Public ☐ Special Education- Type: _____ ☐ Unknown

Section VI Special Needs (Explain any "Yes" answer below)

Special Need	Yes	No	Unknown	Special Need	Yes	No	Unknown	Special Need	Yes	No	Unknown
Medication.	☐	☐	☐	Physical Aggression	☐	☐	☐	Allergies	☐	☐	☐
Pregnant	☐	☐	☐	Verbal Aggression	☐	☐	☐	Fire Starter	☐	☐	☐
Drugs/Alcohol	☐	☐	☐	Runner	☐	☐	☐	Vandalism	☐	☐	☐
Sexual Offender	☐	☐	☐	Disability	☐	☐	☐	Other:	☐	☐	☐
Sexually Abused	☐	☐	☐	Suicidal	☐	☐	☐				

Explanation:

If child is receiving services through a HCBS waiver, please indicate which waiver(s) :

☐ I/DD ☐ SED ☐ TA (Technology Assisted) ☐ PD (Physically Disabled) ☐ TBI (Traumatic Brain Injury) ☐ autism ☐ PRTF

HCBS Waiver Case Manager Information:

Waiver/ Case Manager Name: _____

Address: _____

Phone Number: E-Mail Address:

Finalization Date(s) of any prior finalized adoption(s): _____

Section VII: Other i*nformation available at this time includes:*

THIRD PARTY INSURANCE: _____ Name of insured _____

Address _____

Account number: Group Number

Appointments Scheduled at Time of Referral	Date/Time	Where	With Whom (if applicable)
Case Plan Scheduled for			
Medical			
Mental Health			
Probation Officer			

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CRB Review			
Court			Time of hearing:

Guardian Ad Litem: _____ Phone #: _____

Court Service Officer: _____ Phone #: _____

CASA: _____ Phone #: _____

CRB Coordinator: _____ Phone #: _____

FP Case Manager: _____ Phone #: _____

Other: Phone #:

Attachments

- ☐ ***Court Document/Verification of Custody (Required)***
- ☐ ***Medical Consent (Required)***
- ☐ ***Medical Card (Required)***
- ☐ ***Release of Information (Required)***
- ☐ ***PPS-0110 Authorization to Disclose Information***
- ☐ ***Appendix 5H KSDE Consent for Release of Information***
- ☐ ***Current Photo of Child***

Other (If available in the DCF Case Record)

- ☐ *Immunization Records*
- ☐ *Birth Records*
- ☐ *Social History*
- ☐ *Psychiatric Evaluation*
- ☐ *School Records*
- ☐ *Birth Certificate/Verification*
- ☐ *Social Security Card*
- ☐ *Current Child Case Plan*
- ☐ *Current Family Case Plan*
- ☐ *Medical Records*
- ☐ *Copy of Insurance Card*
- ☐ *Other*