Referral to DCF for Continued Services

(Email to DCF 30 days prior to the end of aftercare.)

SECTION I

Child's Name: _____ **Court Case #:** _____

Referring CWCMP: _____ Date Referred: _____

Referring Case Manager _____ County: _____ Region: _____

Address: _____ Phone: _____

Referred to DCF Service Center: _____

Address: _____ Phone _____

Name of 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:			Father's Address:		
Mother's Phone :			Father's Phone :		
FACTS Client ID #		FACTS Case #		KEES Client ID # upon KEES implementation	

Current location of child: _____

Name: _____ Relationship: _____ Phone _____

SECTION II

Brief Summary of Family Status

Reason for continued court oversight

SECTION III:

Household Members – indicate relationship to the child and legal status of siblings

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SECTION IV ***School Information***

Current School: _____ Current Grade: _____

Address: _____

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

Section V 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) :

☐ MR/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:

Section VI:

Additional Information

Date of Last Case Plan

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

Guardian Ad Litem: _____ Phone #: _____

Court Service Officer: _____ Phone #: _____

CASA: _____ Phone #: _____

CRB Coordinator: _____ Phone #: _____

Other Service Provider: _____ Phone #: _____

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Other Service Provider: Phone #:

Additional Information *(use this space – please attach additional page(s) if necessary)* provide any other pertinent information DCF should have (e.g., family has history of violence, drug abuse, pending JO charges, service provider names if no current appointment is scheduled).

Kansas
Department for Children and Families
Prevention and Protection Services

Strong Families Make a Strong Kansas