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).