|  |  |  |
| --- | --- | --- |
| Case Head Name:       | [ ]  Initial Referral  | [ ]  Resumption of Services |
|  *Last Name First Name MI*  |  |
| Date of Initial referral:  |       | Time of Initial Referral: |       | Date of Resumption of Services: |  |
| Address of family: |       |
| City, State, Zip: |       | County where family resides:       |
| Contact name/number(s) for family:       |       |
| Non- residential parent(s):  | Name:      | Address:       | Phone:      |
|  | Name:       | Address:       | Phone:       |
|  | Name:       | Address:       | Phone:       |
| FACTS Case #(When Available):  |  | CPS Specialist: |       |
| Case Name Client ID #:  |  | CPS Specialist’s Best Contact Number: |       |
| Local DCF Office:  |       | CPS Specialist’s Email: |       |
| DCF Region:  |       | DCF Supervisor: |       |
| Referred to Provider Agency:  |       | DCF Supervisor’s Best Contact Number: |       |
| Family Preservation Liaison Assigned? | [ ]  No [ ]  Yes (*If yes, list name):* | Family Preservation Liaison Phone Number: |       |
| Dates/Times CPS Specialist/Family Preservation Liaison is available for Initial Family Meeting:  |       |
| **SECTION I: Additional Family Information** *Applicable Roles to child: Mother, Father, Step-Parent, unrelated live-in, Aunt, Cousin etc.* |
|  |
| Case Participants/Role (residing in the home) | Case Participants/Role (residing outside of the home) |
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| Date Family Preservation Services accepted?       |
| Date of last contact with family?        | Type of contact: [ ]  In Person [ ]  Phone |
| Are there language barriers? [ ]  No [ ]  Yes | *Explain*:       |
| Has an interpreter been used with this family? [ ]  No [ ]  Yes *(If yes, list name and number below)* |
| Name of Interpreter:        | Contact Number of Interpreter:       |
| Worker Safety Issues: *(Explain)*       |
| Is there a reason to believe that any family member is a member or eligible to be a member of a recognized Tribe, and the Indian Child Welfare Act (ICWA) applies? [ ]  No [ ]  Yes *(If yes, list Tribal Affiliation):*       *Name of Enrolled Family Member(s):*       |
| **SECTION II: Court Involvement** |
| Is/are any child(ren) in this family in DCF custody? [ ]  No [ ]  Yes (*If yes, list names below with date of custody and next court hearing for each)*  |
| Name of Child:       | Date of Custody:       | Next Court Hearing Date:       |
| Name of Child:       | Date of Custody:       | Next Court Hearing Date:       |
| Name of Child:       | Date of Custody:       | Next Court Hearing Date:       |
| Name of Child:       | Date of Custody:       | Next Court Hearing Date:       |
| If there is a child(ren) in custody, when is the next custody case plan due?       |
| Is there other court involvement for any of the family members? [ ]  No [ ]  Yes *(If yes, list names, etc. below)* |
| Name:       | Date/location of Court Hearing:       | Type of Court Hearing\*:       |
| Name:       | Date/location of Court Hearing:       | Type of Court Hearing\*:       |
| Name:       | Date/location of Court Hearing:       | Type of Court Hearing\*:       |
| \*Types of Court Hearings:CINC: Temporary Custody, Adjudication, Disposition, Review, Other:        Juvenile Offender: Adjudication, Disposition, Revocation, Other:       |
| \*Types of Adult Court Hearings*:* Family Court/Divorce Custody; Criminal, Other:       |
| Court Case Number(s):       | Judicial District/County or Judge:       |
| Has the court ordered Family Preservation Services? [ ]  No [ ]  Yes *(If yes, list court date, case number and court below)* |
| Next Court Date(s):       | Court Case Number:       | Judicial District/County or Judge:       |
|       |       |       |
| **Section III: Reason for Referral** |
| **Presenting Problem:** [ ]  Abuse [ ]  Neglect [ ]  Family In Need of Assessment [ ]  Pregnant Woman Using SubstancesIf applicable, check status of child abuse/neglect investigation: [ ]  In Process [ ]  Unsubstantiated [ ]  Affirmed [ ]  Substantiated Is this referral the result of a Juvenile Offender case? [ ]  No [ ]  YesHas the Family Based Assessment (FBA) been completed? [ ]  No [ ]  Yes |
| **Synopsis of Reasons for Referral:**  |
|       |
| Safety Concerns: *(List all safety concerns to be addressed below)*      |
| Protective Factors to Mitigate Safety Concerns: (*Include family’s strengths, resources and actions taken to help protect children; Appendices 2J, 1B, and/or 2F may be used for guides)*      |
| Risk Factors: *(List known risk factors below)*      |
| Protective Factors to Mitigate Risk Factors: (*Include family’s strengths, resources and actions taken to help protect children; Appendices 2J, 1B, and/or 2F may be used for guides)* |
| Prior DCF involvement and/or services? [ ]  No [ ]  Yes If yes, provide details of prior DCF involvement:      |
| **Section IV: Service Needs** |
| Is any family member receiving mental health services? [ ]  No [ ]  Yes (*If yes, complete the* *following:)*Has any family member received mental health services in the past?  |
| Name of Family Member | Name of Past/Current Therapist or Case Manager |
|  |  |
|  |  |
|  |  |
|  |  |
| Does any family member have suspected or confirmed substance use concerns? [ ]  No [ ]  Yes (*If yes, complete the* *following:)* |
| Name of Family Member | Type of Substance Used | Has a drug screen, evaluation, or court confirmed substance use? If yes, when? |
|  |  |  |
|  |  |  |
|  |  |  |
| Is this a Pregnant Woman Using Substances (PWS)? [ ]  No [ ]  Yes | *(If Yes,* *check if opioids or non-opioids)* [ ]  Opioids [ ]  Non-Opioids |
| List current services being provided through a Client Purchase Agreement and indicate if authorized by DCF to continue. If there are no services, write “none” in the space below.  |
| Service | Provider | DCF Approved |
|  |  | [ ]  Yes [ ]  No |
| **Section V: Signatures**  |
| Completed by: | Date: | Time: |
| Supervisor Electronic Signature:  | Date: |  |
| Send the following forms to the Provider (check all that apply):[ ]  PPS 1000 Face sheet – Required[ ]  PPS 2007 Plan of Safe Care per PPM 2050, if applicable[ ]  PPS 2020 Assessment Map[ ]  PPS 2021 Immediate Safety Plan (if applicable)[ ]  PPS 3050 Family Service/Preservation Plan for Child Not in Custody, if applicable[ ]  PPS 3051 Permanency Plan for Child in Custody, if applicableNote: DCF CPS Specialist shall be available to FPS provider staff for two hours following referral. |

Distribution: 1. Provider Agency File 2. Regional Support Services Program Consultant 3. DCF Case Record

