|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **To DCF CPS Specialist:** | |  | | **From Family Preservation Services Provider / Agency** | |  | |
| Date: |  | | Referral Date: |  | Tier 1 | | Tier 2 |
| **Reason for Submission: (Check the applicable boxes below)** | | | | | | | |
| Initial/Acknowledgment of Referral  Drug Toxicology Results/Pregnant Woman Using Substances referral to Medicated-Assisted Treatment  Resumption of Services  Corrected Copy  Status Change  Non-Completion of Case Plan (FACTS code NC01N)  Closure | | | | | | | |
| **SECTION I Case Identifying Information** | | | | | | | |
| Case Name: | |  | | Client ID #: | |  | |
| FACTS Case #: | |  | | Court Case #: | |  | |
| **SECTION II Acknowledgment of Referral** | | | | | | | |
| Date Referral Received by Provider | |  | | Time Referral Received by Provider | | AM  PM | |
| **SECTION III Provider Staff Identifying Information** | | | | | | | |
| Provider Staff Assigned: | |  | | Address: | |  | |
| Worker Phone #: | |  | | 24-Hour Access Phone # | |  | |
| **SECTION IV Pregnant Woman Using Substances** | | | | | | | |
| Infant’s Name: |  | | Date of Birth: | Not Live Birth | Sex: | | Female  Male |
| Race: | American Indian  Asian  Black  White  Native Hawaiian/Pacific Islander  Declined  Unable to determine | | | | | | |
| Ethnicity: | Mexican  Puerto Rican  Cuban  Not Hispanic  Central or South American  Other Spanish Cultural Origin  Unable to determine  Declined to provide information | | | | | | |
| Tribe: | Sac & Fox  Potawatomi  Kickapoo  Iowa  Other:\_\_\_\_\_\_\_  Not applicable | | | | | | |
| (Complete if PWS Using Non-Opioid Substances)  Infant’s Drug Toxicology Test Date:  Not Tested (Opioid Use Only)  Results of infant’s test:  Negative for drugs  Positive for drugs | | | | (Complete if PWS Using Opioids)  Pregnant Woman Referred to a Medication Assisted Treatment (MAT) program (Opioid Use Only)  Date:  No  Reason: | | | |
|  | | | | | | | |
| **SECTION V Case Status Change** | | | | | | | |
|  | | | | **Date:** | **Note:** | | |
| Child released from DCF custody | | | |  |  | | |
| Court venue change (custody only / services transfer to another region) | | | |  |  | | |
| Family cannot be located / disengaged from services | | | |  |  | | |
| Family moved out of state | | | |  |  | | |
| Family placed children out of state | | | |  |  | | |
| Family refused to continue services | | | |  |  | | |
| Family placed children with relatives/kin in another region | | | |  |  | | |
| Family successfully completed services / case conference complete | | | |  |  | | |
| Other (specify) | | | |  |  | | |
| **SECTION VI Case Closure/Payment Cessation** | | | | | | | |
|  | | | | **Date:** | **Note:** | | |
| Family did not sign Family Case Plan/Not engaged in services in 30 days | | | |  |  | | |
| Conclusion of Initial Intensive phase (only use for cases referred prior to 1/1/20) | | | |  |  | | |
| Conclusion of 12-month case responsibility(only use for cases referred prior to 1/1/20) | | | |  |  | | |
| Conclusion of Tier 1 Services | | | |  |  | | |
| Conclusion of Tier 2 Services | | | |  |  | | |
| Family refused to continue services | | | |  |  | | |
| Family Preservation Services ended due to referral for out-of-home placement of child(ren) | | | |  |  | | |
| Other (specify) | | | |  |  | | |

**DISTRIBUTION**

According to local procedures, send to:

Regional Support Services Program Consultant

DCF CPS Specialist/Family Preservation Liaison

DCF Payment Unit/eSCRIPTS

DCF FACTS Unit

