|  |  |  |  |
| --- | --- | --- | --- |
| **To DCF CPS Specialist:** |  | **From Family Preservation Services Provider / Agency** |  |
| Date:  |  | Referral Date: |  |  |  |
| **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[ ]  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:      [ ]  NoReason:       |
|  |
| **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 Family Preservation 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

