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| --- | --- | --- | --- | --- | --- | --- | --- |
| Section I: (Completed by CWCMP or DCF CPS Specialist) | | | | | | | |
| Date of Request: | |  | |  | | | |
| Request made by (name and title): | |  | | Child Welfare Case Management Provider Agency: | |  | |
| Phone Number: | |  | | DCF Region: | |  | |
| Family Preservation Provider Staff / DCF Worker | |  | | DCF Regional FPS Program Consultant or designee: | |  | |
| Section II | | | | | | | |
| Case Name: |  | | FACTS #: |  | Date of Referral | |  |
| Name and ages of children in the home: | | | | | | | |
| Name of other adults in the home: | | | | | | | |
| Reason for referral (complete with information from the PPS 5000 or PPS 4200. The referral form may also be attached): | | | | | | | |
| Reason for Request: (Check box below or explain reason)  Family does not meet criteria for referral  Family member has open case in FACTS for other services  Family remains eligible for services to resume in same tier of services without new referral  Other: | | | | | | | |
| Steps taken by Child Welfare Case Management Provider: | | | | | | | |
| Electronic Signature | |  | | Date: | |  | |
| Section III (to be completed by DCF Regional FPS Program Consultant or Designee) | | | | | | | |
| Date request received from the CW Case Management Provider/DCF Worker: | | | | | |  | |
| Does the DCF Regional FPS Program Consultant or designee agree with the request for retraction? | | | | | | Yes  No | |
| Rationale for decision / Additional Comments: | | | | | | | |
| Retraction Request Approved? | | Yes  No | | Date of Decision: | |  | |
| Submit to DCF Escripts Help at [DCF.EscriptsHelp@ks.gov](mailto:DCF.EscriptsHelp@ks.gov) | | | | | | | |
| Electronic Signature: | |  | | Date: | |  | |
| Distribution:   * Case File * Child Welfare Case Management Provider * DCF Child Protection Specialist | | | | | | | |

