

PPS 4311 Family First Prevention Plan and Service Referral/Case Status Form—Instructions for CPS

Completed by CPS/FC Liaison/IL Coordinator

Effective July 2025

SECTION I: Identifying Information – Completed by CPS/FC Liaison/IL Coordinator

Case Head Name:	Case Head Client ID:	FACTS Case #:	FACTS Event #:
Date of Intake Assignment: Click or tap to enter a date.			
Address of Family: City, State, Zip:		Phone number: Best way to contact family (phone, text, person, other):	
County where family resides:			
Non-custodial Parent(s) Name: Address: City, State, Zip:		Phone: Best way to contact family (phone, text, person, other):	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list Tribal Affiliation):			
Name of Enrolled Family Member(s):			

SECTION I: Identifying Information

- Complete Case Head information (Name, Client ID, Case #, Event #)
- Enter the Date of the Intake's Assignment
- Complete contact information for both Case Head and non-custodial parent (address, phone number, etc.)
- Is the family eligible (already involved) with ICWA? If yes, please list the names.

Referring DCF CPS/ Foster Care Liaison/IL Coordinator:

Email:
Phone number(s):
Supervisor:

Family First Regional Email (check one below):

Northwest Region ☐ DCF.WERFFLiaison@ks.gov

Southwest Region ☐ DCF.WERFFLiaison@ks.gov

Wichita Region ☐ DCF.WROFF@ks.gov

Northeast Region ☐ DCF.NortheastFamilyFirst@ks.gov

Southeast Region ☐ DCF.SoutheastFamilyFirst@ks.gov

KC Region ☐ DCF.KCRegionFamilyFirst@ks.gov

DCF Office:

List any other DCF division or employee actively involved with the family if applicable (Name/role):

SECTION I: Identifying Information

- Complete Referring CPS information (Name, Email, Phone #, and Supervisor)
- Check mark the Region the referral will be active in. ***Hint: The email inbox listed next to the selected Region needs added to the original referral email.**
- Enter the DCF Office the referral is being made from (Referring CPS Office)
- Identify and list any DCF names whom may be actively involved with the family already.

SECTION I: Identifying Information

- Was there PPC prior to the referral being made? If so, please fill out the date PPC ended.
 - Is there a current Child In Need of Care (CINC) case? If yes, please list the Court #, Date of the next Court Hearing, and the Division.
 - Is there a child in the family in DCF custody? If yes, please list the names.
- Please check mark yes or no for the following questions.
- Is this referral due to a Juvenile Offender case?
 - Is the referral for a pregnant youth in Foster Care? If yes, please list the name.

Was any child in PPC prior to referral:

☐ Yes ☐ No If yes, release date of PPC:

Is there a current CINC case:

☐ Yes ☐ No If yes:

Court Number:

Next Court Hearing/Division:

Any child in the family in DCF custody:

☐ Yes ☐ No If yes, Name:

Answer the following ***FACTS CODES** in parentheses:

Is this referral due to a Juvenile Offender case?

☐ Yes **(JO01N)(PSW)** ☐ No

Is the referral for a pregnant youth in foster care?

☐ Yes **(FC01N)(FGC)** ☐ No

If yes, Name:

If the referral is for a parenting youth in foster care is their child:

☐ Not in custody **(FC02N)(FGC)**

☐ In custody of the Secretary **(FC03N)(FGC)**

Name of parenting youth:

Child's name:

SECTION II: Candidacy for Care Determination

- List all names and ages of the children in the home.
- Determine if each child is a Candidacy of Care by check marking yes or no. If yes, please briefly list the reason for imminent risk of removal.

Section II: Candidacy for Care Determination – Completed by CPS/FC Liaison/IL Coordinator –

Determine if the child meets criteria as a candidate for care.

Child Name (List all children in the home)	Age	Candidate for Care	Reason for candidacy determination
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for imminent risk of removal:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for imminent risk of removal:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for imminent risk of removal:

Indicate if any children above have, within approximately a year, participated in mental health treatment, or if any child is on a psychiatric residential treatment facility (PRTF) waitlist. This will assist in service coordination.

Name of child/youth	Agency delivering service	Name of past/current therapist or case manager

Is any child/youth listed above on a PRTF waitlist? ☐ No ☐ Unknown ☐ Yes. If yes, add name of child:

SECTION II: Candidacy for Care Determination

- Within the children listed above being in the home, indicate if any of the children have participated in mental health treatment within the past year. If yes, list the name of the child, the agency delivering the service, and the name of the clinician, if applicable.

Please check mark yes or no for the following question:

- Is the child listed above on a PRTF (Psychiatric Residential Treatment Facility) waiting list? If yes, add the name of the child on the waitlist.

Section III: Prevention Plan – Completed by CPS /FC Liaison/IL Coordinator

A prevention plan expires after 12 months of being open. The prevention plan date will match the start date of the service referral (Section IV). Select one of the following below:

1A. Complete for initial prevention plan (most common)

OR

1B. Complete when services extend beyond 12 months of previous prevention plan

- ☐ This is an initial prevention plan

- ☐ This is an extension of an active prevention plan/that follows an expired prevention plan

Enter the start date for this plan/referral: Click or tap to enter a date.

Enter the start date (use end date from previous plan): Click or tap to enter a date.

Enter the end date (12 months from start date): Click or tap to enter a date.

Enter the end date (12 months from start date): Click or tap to enter a date.

1C: Is this a revision to an open prevention plan? ☐ Yes ☐ No

Reason for revision:

Has this family been actively engaged in conversations about Family First services? ☐ Yes ☐ No

Prevention Strategy (Check one):

- ☐ Maintain the child safely in the home
☐ Live temporarily with a kin caregiver until the child can safely return to their parent(s)/caregiver(s), or
☐ Live permanently with a kin caregiver.

SECTION III: Prevention Plan

A prevention plan expires after 12-months (365 days) of being open.

- If this is an initial prevention plan, check mark the box under 1A. Then, enter the start date (*Hint: this date much match the date the referral is sent via email). Enter the end date—this must be 365 days from the start date, i.e. Start Date: 8/14/2023, End Date: 8/14/2024.

- If this is NOT an initial prevention plan and is an extension of a previous prevention plan, check mark the box under 1B. The start date of an extension must be an end date of the initial prevention plan, i.e. End Date: 8/14/2024, Extension Start Date: 8/14/2024. The Extension's End Date must be 365 days from the Extension Start Date, i.e. 8/14/2025.

- If an initial or extended prevention plan needs revised, check mark yes or no in 1C and provide a brief reason for the revision.

- Has the family been engaged in a conversation about the Family First service you plan to refer to? Check mark yes or no. *Hint: This questions helps our Family First Grantees prepare before approaching the family regarding their service.

Section IV: Family First Prevention Service Referral – Completed by CPS/FC Liaison/IL Coordinator – Check the appropriate service box to identify the service the family agrees to receive available in the county where the family resides.

***NOTE FOR FACTS STAFF: Service is added to all family members.**

Kinship Navigator (BK01N)	Mental Health (EM01N)	Parent Skill Building (FO10N)	Substance Use Disorder (ES01N)
<input type="checkbox"/> Kids 2 Kin – Kansas Legal Services (NIT)	<input type="checkbox"/> MST – Multisystemic Therapy – Community Solutions (MST)	<input type="checkbox"/> Bright Futures Program – KPATA (PAT)	<input type="checkbox"/> START – DCCCA (STA)
	<input type="checkbox"/> Parent Child Interaction Therapy – TFI Family Services (PCI)	Healthy Families America <input type="checkbox"/> KVC (HFB) <input type="checkbox"/> Kansas Children's Service League (HFA) <input type="checkbox"/> Family Mentoring – CAPS (NPP) <input type="checkbox"/> Fostering Prevention – FAC (FSP) <input type="checkbox"/> Family Centered Treatment – Saint Francis (FCT)	<input type="checkbox"/> Parent Child Assistance Program, PCAP – Kansas Children's Service League (PCA) <input type="checkbox"/> Seeking Safety – Saint Francis (SES)

***NOTE FOR FACTS STAFF: (FACTS CODES)**

List all family members/relatives, including any minor children, and non-related kin, in or out of the household who will participate in the service.

Family Member / Role	Is this a new service or a service added to an already existing prevention plan?	Add the date only if this is an additional service.
	<input type="checkbox"/> New <input type="checkbox"/> Additional service	Click or tap to enter a date.
	<input type="checkbox"/> New <input type="checkbox"/> Additional service	Click or tap to enter a date.
	<input type="checkbox"/> New <input type="checkbox"/> Additional service	Click or tap to enter a date.

SECTION IV: Family First Prevention Service Referral

- Check mark the box next to the Family First service selected for the referral. *Hint: Ensure the proper agency is checked.

SECTION IV: Family First Prevention Service Referral

- List all members participating in the Family First service and their roles.
- Check mark new or additional service for each member (an additional service would be utilizing during an appropriate revision. If it is in fact an additional service, add the Start Date for the additional service).

SECTION V: Family First Referral Opening – Completed by CPS/FC Liaison/IL Coordinator

Reason for Referral (Describe what brought the family to the attention of the agency, why is the family being referred for specified services, and historical involvement with agency):

SECTION V: Family First Referral Opening

- This section is any and all pertinent information (please be detailed) to the Family First Grantees (Providers) regarding the need or why behind the referral for the family.
- Please provide a synopsis of the case (do not copy and paste the Intake) including PPC (Police Protective Custody) information, any TDM (Team-Decision Meeting) outcomes, etc.

Required attachments for Family First Prevention Services:

- ☐ A/N referrals; PPS 1000, PPS 2020 Kansas DCF Assessment Map
- ☐ FINA referrals; PPS 1000, PPS 2020 Kansas DCF Assessment Map
- ☐ All cases; PPS 2021 Immediate Safety plan – if applicable
- ☐ Attach and email all forms to the grantee/provider, regional Family First mailbox and your region's FACTS mailbox

(End DCF responsibility, Grantee portion begins next page)

Required Attachments for a Family First Prevention Service Referral

- All Abuse/Neglect & FINA referrals require the PPS 1000 and the PPS 2020.
- All cases require the PPS 2021, if applicable.
- Attach and Email all forms to the Family First Grantee (Provider) (shown in the box below by region), Regional Family First Email Inbox (shown in Section 1), and the Region's FACTS Email Inbox. (shown in the box to the left).

END of DCF's responsibility.

Region	FACTS email inbox	Family First email inbox	Referring Child Protection Specialist or Foster Care Liaison (Listed in Section I)
Northwest	DCF.WERFP@ks.gov	DCF.WERFFLiaison@ks.gov	Both
Southwest	DCF.WERFP@ks.gov	DCF.WERFFLiaison@ks.gov	Both
Wichita	DCF.WROCPFP@ks.gov	DCF.WROFF@ks.gov	Both
Northeast	DCF.EastFacts@ks.gov	DCF.NortheastFamilyFirst@ks.gov	Both
Southeast	DCF.EastFacts@ks.gov	DCF.SoutheastFamilyFirst@ks.gov	Both
Kansas City	DO NOT SEND TO FACTS	DCF.KCRegionFamilyFirst@ks.gov	Both