IOWA Health and Human Services

Child Welfare Services Referral Face Sheet

☐ **Agency Child Welfare Services - Family Casework**		
☐ Family Casework – QRTP Post Discharge Services	☐ Family Preservation Services (Send a separate referral to Parent Partners to attend a CSC)	☐ Parent Partners
☐ SafeCare ☐ One Household ☐ Two Separate Households	☐ Kinship Navigator Services ☐ RRTS ☐ Kinship Foster Care ☐ Foster Care License Study ☐ Adoption Approval Study	☐ Family Interactions ☐ Family Focused Meetings ☐ YTDM Meeting

I. Case Information

Referral Date	Case ID	State ID	
Youngest Child Victim Name	FACS ID	Race	Ethnicity
Date of Birth (DOB)	County of Residence	Financial County	
Any cultural needs and/or special accommodations? ☐ Yes ☐ No If yes, identify:	Is there a need for a translator or interpreter? ☐ Yes ☐ No If yes, language:		
Reason for Referral:			
Family Safety Concerns: What is the reason for HHS involvement? What safety concerns must be addressed? What will safe case closure look like (goals/outcomes)?			

II. HHS Referral Worker, HHS Social Work Case Manager (SWCM), and Supervisor

Referral Worker Name	Referral Worker Contact Number with Area Code	Referral Worker Email Address
Assigned SWCM Name		

SWCM Office Address		
SWCM Contact Number with Area Code and Extension	Fax Number	SWCM Email Address
SWCM Supervisor	Phone Number with Area Code and Extension	Email Address
Dates/Times SWCM Available for Case Handoff/Transition Meeting		
Dates/Times Child Protection Worker (CPW) Available for Case Handoff/Transition Meeting		

III. Family Information

Name of Parent (Household One)	FACS ID	Race	Ethnicity
Name of Parent (Household One)	FACS ID	Race	Ethnicity
Any cultural needs and/or special accommodations? ☐ Yes ☐ No If yes, identify:	Is there a need for a translator or interpreter? ☐ Yes ☐ No If yes, language:		
Household One Address and Contact Number with Area Code			
Name of Parent/Caretaker (Household Two)	FACS ID	Race	Ethnicity
Name of Parent/Caretaker (Household Two)	FACS ID	Race	Ethnicity
Any cultural needs and/or special accommodations? ☐ Yes ☐ No If yes, identify:	Is there a need for a translator or interpreter? ☐ Yes ☐ No If yes, language :		
Household Two Address and Contact Number with Area Code			
Is the youngest child victim in an out-of-home placement by order of the Court? ☐ Yes ☐ No	Date of Removal from Home		
Is the youngest child victim temporarily out of the home through a Safety Plan? ☐ Yes ☐ No	Date of Placement		
Name of Placement	Is there a current **Family Interaction Plan?** ☐ Yes ☐ No		
Address of Placement	Type of Placement		

Phone Number of Placement with Area Code	Contact Person Name

IV. Family Composition

Role	Name (last, first)	DOB	Race/ Ethnicity	Relationship to Youngest Child Victim	Address and Phone with Area Code
Parent in the Home			/		
Parent in the Home			/		
Caretaking Adult			/		
Caretaking Adult			/		
Child (Youngest Child Victim Name)			/		
Child (Victim or CINA)			/		
Child (Victim or CINA)			/		
Child (Victim or CINA)			/		
Child (Sibling/ Household)			/		
Child (Sibling/ Household)			/		
Child (Sibling/ Household)			/		
Child (Sibling/ Household)			/		
Parent Not Residing in Home			/		
Parent Not Residing in Home			/		

Agency Child Welfare Services - Family Casework Post QRTP-Discharge

QRTP and Court Involvement

Hearing	Most Recent Date	Next Scheduled Date	County of Court Jurisdiction
Juvenile Court:			
If the referral is for QRTP Post Discharge Services, please enter the following: QRTP Contact: QRTP Discharge Date:			

Current Services and Supports

Type of Service or Support	Name of Contact Person, Address, and Phone Number with Area Code	Date Services or Supports Began
☐ Domestic Violence (DV)		
☐ Substance abuse (SA)		
☐ Mental health (MH)		
☐ Parent partner		
☐ Behavioral health intervention services (BHIS)		
☐ Integrated health homes (IHH)		
☐ Adult probation or parole (requirements)		
☐ Treatment court		
☐ Other		
☐ Other		

Family Preservation Services (families who have children at imminent risk of removal and placement out of home)

Describe the threats of danger placing the child(ren) at imminent risk of removal:

Is there a current open child abuse assessment? ☐ Yes ☐ No

Is there a current open CINA assessment? ☐ Yes ☐ No

Is there an open ongoing Agency service case? ☐ Yes ☐ No

SafeCare (families with a child under six years of age)

Do any of the following concerns exist about the parent/caregiver's ability to:

	Household One		Household Two	
Engage/bond with their infant?	☐ Yes	☐ No	☐ Yes	☐ No
Structure daily activities that stimulate their child?	☐ Yes	☐ No	☐ Yes	☐ No

	Household One		Household Two	
Manage their toddler's behaviors?	☐ Yes	☐ No	☐ Yes	☐ No
Maintain a safe home?	☐ Yes	☐ No	☐ Yes	☐ No
Make good health decisions for their child?	☐ Yes	☐ No	☐ Yes	☐ No

Parent Partners (send referral form to the Parent Partner coordinator)

Participant Family Information

Referred Participant Name (last, first)	Referred Participant Name (last, first)	
County of Court Jurisdiction		
Have the participants been involved in child protective services before?	☐ Yes	☐ No
Do the participants know a referral was made to Parent Partners?	☐ Yes	☐ No

Kinship Navigator Services or RRTS

Purpose of referral:

☐ Kinship Navigator Services ☐ RRTS:

☐ KFC Home Study ☐ Foster Care License Home Study ☐ Adoption Home Study

☐ Billing Child - Kinship Caregiver Information*

Name(s)	Phone/Cell Number with Area Code
Home Address	Email
Relationship to the child(ren)	Date of placement with kinship caregiver

*If siblings are not placed together in the same kinship caregiver home, include additional kinship caregiver information below regarding siblings.

Siblings - Kinship Caregiver Information

Name(s)	Phone/Cell Number with Area Code
Home Address	Email
Relationship to the child(ren)	Date of placement with kinship caregiver
Name(s)	Phone/Cell Number with Area Code
Home Address	Email
Relationship to the child(ren)	Date of placement with kinship caregiver

NOTE: If more than one kinship caregiver is listed, it is considered more than one referral (i.e. if children are placed with two separate kinship caregiver families, this would be considered two separate referrals for kinship navigator services).

Identified Needs, Supports, and Additional Information of Kinship Caregivers

List any current identified needs of the kinship caregiver at time of referral:
List any current identified supports for the kinship caregiver at time of referral:
List any additional information the kinship specialist should know in preparation of contacting the kinship caregiver family:

Family Interactions

Provide the information below to aid in Family Interaction planning and complete the Family Interaction Plan, Form 470-5148.

Child care provider name(s), address(es), and phone(s):

School name(s) and address(es):

Family Focused Meeting (FFM) or Youth Transition Decision-Making (YTDM) Meeting

Meeting Type	Most Recent Date	Next Scheduled Date
FFM		
YTDM Meeting		

Type of referral:

- ☐ Comprehensive FFM (within 45-60 calendar days from the date of referral to services)
- ☐ Follow-up FFM
  - ☐ Six months from the date of referral to services
  - ☐ 12 months from the date of referral to services and every six months the case remains open
  - ☐ Upon family request
  - ☐ Prior to case closure
- ☐ Other
  - ☐ when HHS determines that an FFM is needed to address child safety
  - ☐ when the family needs the assistance of others to achieve next steps with their case plan
  - ☐ when opportunities arise to recognize and celebrate change and identify what is left to accomplish

What is the desired outcome of this meeting?

What changes have occurred with the family since the prior YTDM?

- ☐ YTDM Meeting - on or after the youth's 16th birthday
- ☐ YTDM Meeting - within 90 days prior to youth's 18th birthday

Check the boxes that apply.

☐ Yes ☐ No Is the family/youth aware a facilitator will be contacting them?

☐ Yes ☐ No Is court involved? If yes, provide:
Date Time Type of Next Hearing

☐ Yes ☐ No Is there a **No Contact Order** in place?
If yes, between who?
Are separate meetings required? ☐ Yes ☐ No

☐ Yes ☐ No Any cultural needs and/or special accommodations?
If yes, identify:

☐ Yes ☐ No Is there a need for a translator or interpreter? Language:

☐ Yes ☐ No Is there a current **Family Interaction Plan** developed and in place?

V. Potential Team Members

Member	Name	Email	Phone with Area Code
HHS Social Work Case Manager (SWCM)			
Child Protection Worker (CPW)			
Family Support Specialist (FSS)			
Intervention Specialist (IS)			
Child's Attorney/GAL			
CASA			
Mother's Attorney			
Father's Attorney			
Parent Partner			
Resource Family			
Kin/Fictive Kin			
Family Supports			
Other/Role			
Other/Role			

Attachments to this referral face sheet:

Attached	Not Available	
☐	☐	3055
☐	☐	Safety Plan (if applicable)
☐	☐	Current Case Plan
☐	☐	Most recent Court Order (if applicable)
☐	☐	Child Abuse Assessment Summary Report/CINA Assessment Summary Report
☐	☐	Family Interaction Plan (if applicable and completed)
☐	☐	FFM or YTDM Meeting Notes
☐	☐	Kinship Home Assessment Part 1 (provide with Kinship Navigator Referral)