

Child Welfare Services Referral Face Sheet

<input type="checkbox"/> Agency Child Welfare Services - Family Casework		
<input type="checkbox"/> Family Casework – QRTP Post Discharge Services	<input type="checkbox"/> Family Preservation Services	<input type="checkbox"/> Parent Partners
<input type="checkbox"/> SafeCare <input type="checkbox"/> One Household <input type="checkbox"/> Two Separate Households	<input type="checkbox"/> Kinship Navigator Services <input type="checkbox"/> RRTS	<input type="checkbox"/> Warm handoff/Initial FFM <input type="checkbox"/> Comprehensive FFM <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify:	Is there a need for a translator or interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Information

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify:	Is there a need for a translator or interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify:	Is there a need for a translator or interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Removal from Home		
Is the youngest child victim temporarily out of the home through a Safety Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Placement		
Name of Placement	Is there a current <i>Family Interaction Plan</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address of Placement	Type of Placement		

Phone Number of Placement with Area Code	Contact Person Name
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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
<input type="checkbox"/> Domestic Violence (DV)		
<input type="checkbox"/> Substance abuse (SA)		
<input type="checkbox"/> Mental health (MH)		
<input type="checkbox"/> Parent partner		
<input type="checkbox"/> Behavioral health intervention services (BHIS)		
<input type="checkbox"/> Integrated health homes (IHH)		
<input type="checkbox"/> Adult probation or parole (requirements)		
<input type="checkbox"/> Treatment court		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Family Preservation Services (families who have children at imminent risk of removal and placement into foster care)

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Structure daily activities that stimulate their child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Manage their toddler's behaviors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Maintain a safe home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Make good health decisions for their child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do the participants know a referral was made to Parent Partners?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Kinship Navigator Services or RRTS

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

Meeting Type	Most Recent Date	Next Scheduled	
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 FFM?

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	
<input type="checkbox"/>	<input type="checkbox"/>	3055
<input type="checkbox"/>	<input type="checkbox"/>	CPW Safety Plan (if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	Current Case Plan
<input type="checkbox"/>	<input type="checkbox"/>	Most recent Court Order (if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse Assessment Summary Report/CINA Assessment Summary Report
<input type="checkbox"/>	<input type="checkbox"/>	Family Interaction Plan (if applicable and completed)
<input type="checkbox"/>	<input type="checkbox"/>	FFM or YTDM Meeting Notes