|  |  |
| --- | --- |
| **Is my family eligible for Project Connect?** *If one or more of the items below are applicable to your family, your family may be eligible for Project Connect* | |
| Was substance use and/or exposure the reason for the removal? | Y ☐ N ☐ |
| Does the parent, caregiver or youth’s substance use impede or is it a barrier to reunification or for the children to remain safely in the home? | Y ☐ N ☐ |
| Does the parent’s substance use impact their ability to care for and provide a safe environment for their child? | Y ☐ N ☐ |
| Is the parent/caregivers substance use a current concern or are there presenting concerns that lead you to believe the parent/caregiver is at high risk for relapse? | Y ☐ N ☐ |

|  |  |
| --- | --- |
| **Please indicate referral source:** | |
| ACEFS | ☐ |
| CPS | ☐ |
| In Home | ☐ |
| Permanency | ☐ |
| Private Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ |

**Referral Date**: Enter date.

|  |  |
| --- | --- |
| **Section a. CFSA/ Private Provider Social Worker Information:** | |
| Social Worker Name: | |
| Phone Number: | Email Address: |
| Social Worker Supervisor Name: | |
| Phone Number: | Email Address: |

|  |  |  |
| --- | --- | --- |
| **Section B. Parent Information:** | | |
| Parent Name: | | |
| Date of Birth: Enter date. | Phone Number: | |
| Address: | | Ward: |
| Parent Client ID Number: | Parent Case ID Number: | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section C. Child (ren) Information: Please use drop down boxes** | | | | |
| *Child’s Name* | *Date of Birth* | *Home Status (current placement of child)* | *Date of Removal* | *Legal Status* |
| 1. | Enter date. | Choose an item. | Enter date. | Choose an item. |
| 2. | Enter date. | Choose an item. | Enter date. | Choose an item. |
| 3. | Enter date. | Choose an item. | Enter date. | Choose an item. |
| 4. | Enter date. | Choose an item. | Enter date. | Choose an item. |
| 5. | Enter date. | Choose an item. | Enter date. | Choose an item. |

|  |
| --- |
| **Section D. Goals and Barrier Information:** |

1. Length of time family has been involved with CFSA and reason for involvement?

|  |
| --- |
|  |

1. What is the next scheduled court date?

|  |
| --- |
| Click here to enter a date. |

1. What is the permanency plan/goal?

|  |
| --- |
| Choose an item. |

1. What are the barriers and /or complicating factors that may result in removal?

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Section E. Substance Abuse History:** | |
| Is substance use treatment in case plan? Y ☐ N ☐ | |
| Is Recovery Specialist involved: Y ☐ N ☐ | Name: |
| Has APRA assessment been completed? Y ☐ N ☐  If yes, what are the recommendations. Please explain below *(if you have a copy of the assessment, please attach in lieu of writing narrative below)* | |

|  |
| --- |
| **Section G. Please include any additional information about the family and/or case below, which may be helpful.**  **(i.e. currently homeless, receiving in/out patient treatment etc.)** |
|  |

|  |  |
| --- | --- |
| **Approval:** | |
| ***Has CFSA Social Worker Supervisor Approved the Application: Y ☐ N ☐*** | |
| Social Worker Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: Click here to enter a date. |

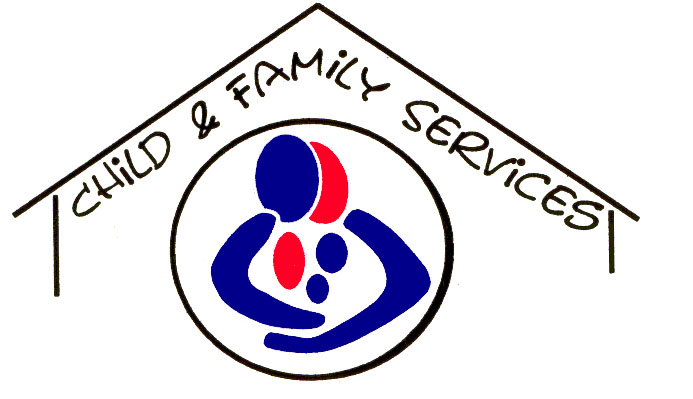
Please include the following documents for all Project Connect Referrals:

1. Project Connect Referral Form
2. Background Information Summary (use attached form)
3. Most Recent Investigation Summary
4. Case Plan (if applicable)
5. Court Date and Report (if applicable)
6. Most recent snapshot/intake summary (if applicable)

Please complete and return Project Connect applications to [cfsa.projectconnect@dc.gov](file:///C:\Users\stephanie.boyd\Documents\Project%20Connect\cfsa.projectconnect@dc.gov)

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

Child and Family Services Agency



Substance Use/Exposure and Mental Health

Background Information

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a detailed paragraph for each of the categories below.

**Substance Abuse (current or previous use/exposure):**

**Mental Health:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Name

Social Worker Social Work Supervisor

Division or Unit Division or Unit