**GOVERNMENT OF THE DISTRICT OF COLUMBIA**Child and Family Services Agency



**COLLABORATIVE REFERRAL FORM**

The five Collaboratives have the following core program service areas:

**CASE MANAGEMENT SERVICES**Case management services responsible for the child and family assessment, development and implementation of case plans. Identifying service providers to ensure the individual needs of the child, youth, or family are being met through the prompt and effective delivery of services to fulfill the case plan requirements and the comprehensive case plan.

**ESSENTIAL CORE SERVICES**

* Emergency Family Flexible Funds
* Respite services
* Support groups and trainings
* Information and Referral
* Mentoring/Tutoring
* Educational Workshops
* Whole Family Enrichment
* Parent Education and Support

**OTHER**

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| ***CASE REFERRAL FORM TO THE COLLABORATIVE***  (PLEASE ATTACH CLIENTS AUTHORIZATION TO REFER AND DISCLOSE PLEASE SUBMIT SINGLE SIDED WITH PAPER  CLIPS PLEASAE DO NOT STAPLE) | | |
| **Choose Collaborative:**  Collaborative Solutions for  Communities (Ward 1, 2 and 3)  Georgia Avenue (Ward 4)  Edgewood/Brookland (Wards 5 & 6)  East River (Ward 7)  Far Southeast (Ward 8) | **Case Type:**  **Front Yard** (community prevention/no CFSA involvement)   * Young/Homeless * GrandFamilies * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Front Porch** (CFSA involvement ending)   * Community Diverted * Family Assessment * In-Home/Permanency Step Down   **Front Door** (Teaming /CFSA leading)   * In-Home or Permanency Teaming   **Referral Origin:**  Community Prevention (no CFSA involvement)  CPS-Investigations  CPS - Family Assessment  In-Home  Permanency  Private Agency  *Please confirm private agency.*  Boys Town of Washington  Family Matters of Greater Washington  Latin American Youth Center  Lutheran Social Services  National Center for Children & Families  PSI Family Services  Seraaj Family Homes | **Referral/Case Number:**  Referral # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CFSA Case #   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*For primary case management referrals, please indicate the top three (3) priority family needs.*

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| *1.* |
| *2.* |
| *3.* |

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|  | ***CASE REFERRAL FORM TO THE COLLABORATIVE (continued)***  (PLEASE ATTACH CLIENTS AUTHORIZATION TO REFER AND DISCLOSE PLEASE SUBMIT SINGLE SIDED WITH PAPER  CLIPS PLEASAE DO NOT STAPLE) | | | |
|  | 1. **IDENTIFYING INFOMRATION** | | | |
|  | 1. Date of Last Internal or External Case Staffing Click here to enter a date. (attach summary of staffing) 2. Was there an FTM conducted in the last 60 days? (  Yes  No attach plan)   3. Has a Red Team occurred for this family? (  Yes  No )If yes, please indicate date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (attach summary)  4. Has anyone in the family used Collaborative services in the last 12 months? If yes, please identify Collaborative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | **Person Requesting the Service:**  **Mother**  **Father**  **Other** **Caretaker** | | | |
| 1. **Parent(s) Information** | |  | **Head of Household** | **Secondary Report/Caretaker Information** |
| **Name** | |  |  |  |
| **Address** | |  |  |  |
| **City/State/Zip** | |  |  |  |
| **Date of Birth** Click here to enter a date. | |  |  |  |
| **Telephone Number** | |  |  |  |

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| **Source of Income**  TANF  SSI  Self Employed  Unemployment Benefits  Child Support  Survivor Benefits  Other |

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| 1. **Children**   Choose an item. | **At Home** | **Out of Home** |  | **D.O.B.** | **Sex** | **Address** |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |
|  | Yes  No | Yes  No | **Legal Status :** | Click here to enter a date. | Choose an item. |  |

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| 1. **CFSA INVOLVEMENT** |
| 1. Case/Referral Information |
| CFSA Referral Date: Click here to enter a date. CFSA Active Case Open Date (if applicable :) Click here to enter a date.  Will children return home in 90-120 days? Click here to enter a date. |
| 1. Reason for CFSA involvement: |
| 1. What were the allegations?  If applicable, please attach the Danger and Safety Assessment, Risk Assessment, Risk Reassessment and [permanency]  |  |  | | --- | --- | | 1. **Number of Allegations**   Choose an item. | **Findings** | | **Allegation** | Substantiated  Unfounded  Inconclusive | | **Allegation** | Substantiated  Unfounded  Inconclusive | | **Allegation** | Substantiated  Unfounded  Inconclusive | | **Allegation** | Substantiated  Unfounded  Inconclusive | | **Allegation** | Substantiated  Unfounded  Inconclusive | | **Allegation** | Substantiated  Unfounded  Inconclusive | |
| 1. Previous Involvement with CFSA  Yes  No   Previous Involvement with Court?  Yes  No If yes, when was the last court date (ex. 3 months) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Please provide details on court involvement below. |
| 1. Services Required (Detail what you would like to change to alleviate risk) 2. **Evaluations and Assessments**   Please check all that apply   |  |  | | --- | --- | | No  In Process  Completed | 1. Ages & Stages Questionnaire | | No  In Process  Completed | 1. Caregivers Strengths and Barriers | | No  In Process  Completed | 1. CAFAS or PECFAS | | No  In Process  Completed | 1. Health Services Referral | |
| 1. **Referring Worker’s Information** |
| Date of Assessment: Click here to enter a date. Date of Referral: Click here to enter a date.   Agency Name:    CFSA Social Worker: Email Address:    CFSA Social Worker Phone Number (s):  Office Number: Cell Number:  **CFSA Social Worker Signature: Date:**    CFSA Social Worker Supervisor: Email Address:  CFSA Social Worker Supervisor Phone Number (s):  Office Number: Cell Number:  **CFSA Social Worker Supervisor Signature: Date:** |

**ATTACHMENTS:**

Case Plan

FTM Plan

Assessment(s)

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

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

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Other

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| **DO NOT WRITE BELOW THIS LINE**  **FOR COMMUNITY PARTNERSHIPS OFFICE USE ONLY:**    Inappropriate Services Request  More Details |
| **FOR COLLABORATIVE USE ONLY**  **This page should be completed and returned to** [**cfsa.collabreferrals@dc.gov**](mailto:cfsa.collabreferrals@dc.gov) **each Monday by noon for all new referrals for the prior week** |
| **Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Case/Referral Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **III DISPOSITION OF CASE REFERRAL** |
| 1. Referral accepted by Collaborative for Services  Yes  No 2. Collaborative Worker Assigned to Case:  Yes  No 3. Name of Assigned Collaborative Worker:­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Date of case assignment (should be one business day from referral date above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Family Engagement**   1. Family Refused Services  Yes  No 2. Family Accepted Services?  Yes  No 3. Date of service linkage :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Has the there been a Pre Case Transfer Staffing? (  Yes  No )If yes, please indicate date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (attach summary) 5. Has the there been a Partnering Together Conference/joint home visit? (  Yes  No ) 6. If yes, please indicate date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (attach summary) 7. If PTC/joint home visit did not occur, please indicate the reasonable efforts made      1. Has three Unsuccessful Home Visits Occurred  Yes  No 2. Comment: |