

Division of Family & Children Services

Two Peachtree Street, NW ▪ Suite 19-490 ▪ Atlanta, GA 30303 ▪ 404-651-8409 ▪ 404-657-5105 (Fax)

**Nathan Deal, Governor Bobby D. Cagle, Interim Director**

**Family Visitation Services**

**SafeCare® and Family Fusion Initial Referral Form**

**Initial Referral Disposition**

SHINES Service Authorization #:       Case ID #:       Region/County:

Date of Referral:       Case Manager:        Phone Number:       Email:

Providing Agency: Children First Inc Supervisor Name:       Phone Number:       Email:

**Referral Source- Division of Family & Children Services**

Intake/Family Support (Family Fusion)  Investigations/ Family Support (Family Fusion)  **Un-Sub (CAPTA/Family Fusion)**

Family Preservation (SafeCare)  Foster Care (SafeCare)  Independent Living (SafeCare)

**Reason for Referral/Comments:**

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

**Household Occupants**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **First Name** | **Last Name** | **Gender**  **(M/F)** | **Race**  **(B, W, L,O)** | **Date of Birth** | **Client**  **ID #** | **Relationship** | **Occupation** | **# of Years of School** |
| **Primary**  **Parent/Guardian** |  |  |  |  |  |  |  |  |  |
| **2nd**  **Parent/Guardian** |  |  |  |  |  |  |  |  |  |
| **Child 1** |  |  |  |  |  |  |  |  |  |
| **Child 2** |  |  |  |  |  |  |  |  |  |
| **Child 3** |  |  |  |  |  |  |  |  |  |
| **Child 4** |  |  |  |  |  |  |  |  |  |
| **Child 5** |  |  |  |  |  |  |  |  |  |
| **Other: Adult #1** |  |  |  |  |  |  |  |  |  |
| **Other: Adult #2** |  |  |  |  |  |  |  |  |  |

Address (Street, City, Zip):      Home Phone:       Cell Phone:

Relative Contact: Name:      Phone Number:

**If the child(ren) are in foster care, please complete the following:**

Foster Parent:  Address:  City:  Zip:

Home Phone:  Cell Phone:  Work Phone:

**If children are with Biological Parent or Relative Placement, please complete the following re: the Parent or Relative:**

DOB:  Ethnicity:  Last 4 Digits of SSN:

Marital Status: Educational Level:  Estimated Annual Income:

Source of Income:

FT Employment PT Employment Food Stamps Child Support Relative Subsidy  Retirement Social Security

SSI TANF  Unemployment  VA – Veteran’s Admin  Workman’s Comp  WIC

**DFCS Screening**

Was the referral screened for current or prior DFCS involvement?  Yes  No

Result:  No prior CPS history  Prior CPS history --  Substantiated or  Unsubstantiated  Current CPS/Family Support case **Family Visitation Services**

**“SafeCare® and Family Fusion” Initial Referral Form (p. 2)**

**Case Assignment**

**SafeCare/Family Fusion Provider: Children First** **Referral Accepted:**  **Referral Denied**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Denial Reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Visitor Assigned: **Mary-Eleanor Joyce** Phone #: **706-613-1922x1** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: **mary@childrenfirst-inc.org**

**Specific Service Requested**

Family Fusion (Basic)  Family Fusion (Intermediate)  SafeCare (Intensive Services)

**Referral Reason**

Prevention Safety  Parental Capacity Building  Medical Neglect  Neglect/Maltreatment

Mental Health  Domestic Violence  Sexual Trauma  Substance Abuse  Physical Abuse

**Initial Family Contact**

Initial Introductory Contact: 1st Call Date:   /  /     Time:       2nd Call Date:   /  /    \_ Time:

3rd Call Date:   /  /     Time:            1st Home Attempt Date:   /  /     Time:

Option A: Contact Made --  Family Accepts Home Visit -- Date Home Visit Scheduled:   /  /

Family Too Busy  Family Refused Home Visit -- Reason:  Family Not Interested

(If Option A, and family accepts home visit, complete information in next section. Otherwise, stop here.)

Option B: Unable to Contact --  Phone disconnected/Wrong number  Wrong address/Unable to locate

(If Option B, no further information required on form)

**Program Overview Visit**

Program Overview Visit Date:   /  /

Option A: Family Enrolled -- Enrollment Date:   /  /      Family Signed Consent Form

Option B: Family Did Not Enroll/Refused Services -- Refusal Date:   /  /

Reason for Refusal –Reason:  Family Not Interested  Family Too Busy

**SafeCare® Home Visiting Program**

First Session/Baseline Visit Date:   /  /     Starting Module:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Upon completion of this form by the Home Visitor, the Family Preservation Provider must ensure the form is sent via email to** [**kdlee@dhr.state.ga.us**](mailto:kdlee@dhr.state.ga.us) **and** [**tglasheen@gsu.edu**](mailto:tglasheen@gsu.edu) **within 48 hours of acceptance.**