STATE OF GEORGIA Division of Family and Children Services

**Prevention and Community Services**

**SafeCare® Augmented Initial Referral Form**

**Initial Referral Disposition**

Providing Agency: Children First, Inc Case ID #:       Region/County:

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

Supervisor Name:       Phone Number:       Email:

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

Intake/Family Support  Investigations/ Family Support Un-Sub Family Preservation  Foster Care Independent Living

**Reason for Referral \*\*REQUIRED\*\* - brief overview of what brought the family to the attention of DFCS and current parenting issues.**

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

**Household Occupants**

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

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:** (If children are in multiple homes, please contact SafeCare with info**)**

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:

Income Source: 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, Inc** Referral Accepted:  Referral Denied  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Home Visitor Assigned: Date: \_\_\_\_\_\_\_\_\_

Phone #: **706-613-1922x** Email Address:

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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) **within 48 hours of acceptance.**