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