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: Select   Educational Level: Select   Estimated Annual Income: Select
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 #: ________________ 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:

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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 within 48 hours of acceptance.