

DCFS/FINS FRC Referral and Intake Form

Case Name: _____ **TIPS #** _____ **Open Date:** _____

A. Referral Source Contact Information			
Office: _____	Supervisor: _____		
Worker: _____	Email: _____ @la.gov		
Email: _____ @la.gov	Email: _____ @la.gov		
Work/Cell Phone: W _____ C _____	Work/Cell Phone: W _____ C _____		

B. Referral Information	
Case Number (for FRC use only) _____	
1. Referral Date to FRC _____	
2. Referral Source	<input type="checkbox"/> DCFS <input type="checkbox"/> FINS <input type="checkbox"/> SELF <input type="checkbox"/> ILP <input type="checkbox"/> EFC <input type="checkbox"/> Referral Program <input type="checkbox"/> CPS <input type="checkbox"/> FS <input type="checkbox"/> SP <input type="checkbox"/> FC <input type="checkbox"/> HD <input type="checkbox"/> AD-FC <input type="checkbox"/> AD-SUB <input type="checkbox"/> ILP <input type="checkbox"/> EFC
4. Family Type	<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Young Adult Setting <input type="checkbox"/> Foster Child or Former FC with infant
5. Family Size _____	
6. Court Status	<input type="checkbox"/> Yes <input type="checkbox"/> No Are services court ordered? If yes, next court date: _____
7. SDM Rating	<input type="checkbox"/> LOW <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH <input type="checkbox"/> VERY HIGH
8. Case Plan Goal (check all that apply)	
<input type="checkbox"/> FS Prevent Placement Out of Home <input type="checkbox"/> FS Reunite Family <input type="checkbox"/> FC/SP Reunify with Parent or Caregiver <input type="checkbox"/> FC/SP Guardianship/Relative Custody (Act 278, 2006) <input type="checkbox"/> FC/SP Alternative Permanent Living Arrangement (APLA) <input type="checkbox"/> FC/AD Child Care Deficiency in Foster/Adoptive Home <input type="checkbox"/> FC/AD Stabilize Pre-Adoption Placement <input type="checkbox"/> EFC Achieve Independent Living (AIL) <input type="checkbox"/> Stabilize Post Adoption Placement <input type="checkbox"/> Youth with Infant – Develop skill to provide safe care of child	
9. Reason for Referral (check all that apply)	
<input type="checkbox"/> Child Management/Behavior <input type="checkbox"/> Child Care Deficiency <input type="checkbox"/> Permanency – Reunification <input type="checkbox"/> Parental Support <input type="checkbox"/> Child Educational Issues <input type="checkbox"/> Safety – Prevent CA/N <input type="checkbox"/> Permanency - Maintain Placement <input type="checkbox"/> Young Adult Support	
10. Services Requested:	
<input type="checkbox"/> Parenting Education <input type="checkbox"/> Family Skills Building <input type="checkbox"/> My Community Cares <input type="checkbox"/> Parent Partner <input type="checkbox"/> Kinship Navigator <input type="checkbox"/> Other: _____ _____ _____	

C. Attachments	
<input type="checkbox"/> Form 5 (as applicable)	<input type="checkbox"/> Form 5 Safety Assessment <input type="checkbox"/> Form 5-CSP Court Ordered Safety Plan <input type="checkbox"/> Form 5-ISP Instanter Order Safety Plan <input type="checkbox"/> Form 5-SP CW Safety Plan
<input type="checkbox"/> One of the following	<input type="checkbox"/> Verified Complaint/Instanter (for Valid cases) OR <input type="checkbox"/> Form 6 – Referral /Transfer Form (Cases referred to FS or FC by source other than CPS) OR <input type="checkbox"/> Form XI - CA/N Out of Home Care Investigative Report for valid findings where services are being requested for foster/adoptive home
<input type="checkbox"/> TBH - Trauma and Behavioral Health Screen	Child & caregiver version--children 7 and older Caregiver version--children 6 years and under
<input type="checkbox"/> FATS Assessment of Family Functioning	
<input type="checkbox"/> FATS Case Plan(s) and YTP(s)	
<input type="checkbox"/> FINS Forms when applicable	
<input type="checkbox"/> Other:	_____ _____ _____
If documents are not available at time of referral, submit as soon as available.	

D. Additional Case Information (i.e. other services currently receiving; domains of concern on Family Assessment; safety concerns; client willingness to receive services; transportation issues, and/or information about any protective orders):

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Case Name: _____ **TIPS #** _____ **Open Date:** _____

E. Case Name / Head of Household (HH) Adult #1	
1.	Full Name _____
2/3.	Age/Gender _____
4/5.	DOB/TIPS # _____
6/7.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
8.	Marital Status _____
9.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Physical Address _____
11.	City/State/ZIP _____
12.	Mailing Address _____
13.	City/State/ZIP _____
14.	Parish _____
15/16.	Phone/Alternate Phone _____
17.	E-Mail Address _____
18.	Emergency Contact Name/Phone _____
19.	Education Level _____
20.	Employer Name _____
21.	Special Circumstances (check all that apply)
<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Disability
<input type="checkbox"/>	Criminal Record
<input type="checkbox"/>	Substance Use/Abuse
<input type="checkbox"/>	Trafficking Victim
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Violent Potential
<input type="checkbox"/>	Domestic Violence
<input type="checkbox"/>	Homicidal
<input type="checkbox"/>	Suicidal
<input type="checkbox"/>	LGBTQ Issues
22.	Does the HH have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Is there a Protective Order in place for parent or child? <input type="checkbox"/> Yes <input type="checkbox"/> No

F. Other Adult Adult #2	
Adult Household/Family Members/Other Adults (18 years and older) who are part of case or are receiving services.	
1.	Full Name _____
2/3/4.	Age/Gender/Rel. to HH _____
5/6.	DOB/TIPS # _____
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
9.	Marital Status _____
10.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Physical Address _____
12.	City/State/ZIP _____
13.	Phone/Alternate Phone _____
14/15.	Emergency Contact Name/Phone _____
16.	Educational Level _____
17.	Employer Name _____
18.	Special Circumstances (check all that apply.)
<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Disability
<input type="checkbox"/>	Criminal Record
<input type="checkbox"/>	Substance Use/Abuse
<input type="checkbox"/>	Trafficking Victim
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Violent Potential
<input type="checkbox"/>	Domestic Violence
<input type="checkbox"/>	Homicidal
<input type="checkbox"/>	Suicidal
<input type="checkbox"/>	LGBTQ Issues
19.	Does this person have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Is there a Protective Order in place for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No

For additional adults use Addendum—Additional Adults page 4.

	<input type="checkbox"/> Child #1	<input type="checkbox"/> Young Adult #1
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable)	
<input type="checkbox"/>	Too young	<input type="checkbox"/> Expelled
<input type="checkbox"/>	Pregnant	<input type="checkbox"/> Suspended
<input type="checkbox"/>	Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box):	
<input type="checkbox"/>	Parent(s)	<input type="checkbox"/> Specialized Foster Home
<input type="checkbox"/>	Regular Foster Home	<input type="checkbox"/> AFC
<input type="checkbox"/>	Relative Foster Home	<input type="checkbox"/> TFC
<input type="checkbox"/>	Relative Placement	<input type="checkbox"/> Trial Home Visit
<input type="checkbox"/>	Pre-Adoptive	<input type="checkbox"/> Post-Adoptive
<input type="checkbox"/>		<input type="checkbox"/> Young Adult Setting
18.	Permanency Goal (If applicable)	
<input type="checkbox"/>	Reunification	<input type="checkbox"/> Maintain Family
<input type="checkbox"/>	Adoption	<input type="checkbox"/> Live with Relative
<input type="checkbox"/>	APLA	<input type="checkbox"/> AIL
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE)	

	<input type="checkbox"/> Child #2	<input type="checkbox"/> Young Adult #2
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable)	
<input type="checkbox"/>	Too young	<input type="checkbox"/> Expelled
<input type="checkbox"/>	Pregnant	<input type="checkbox"/> Suspended
<input type="checkbox"/>	Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box):	
<input type="checkbox"/>	Parent(s)	<input type="checkbox"/> Specialized Foster Home
<input type="checkbox"/>	Regular Foster Home	<input type="checkbox"/> AFC
<input type="checkbox"/>	Relative Foster Home	<input type="checkbox"/> TFC
<input type="checkbox"/>	Relative Placement	<input type="checkbox"/> Trial Home Visit
<input type="checkbox"/>	Pre-Adoptive	<input type="checkbox"/> Post-Adoptive
<input type="checkbox"/>		<input type="checkbox"/> Young Adult Setting
18.	Permanency Goal (If applicable)	
<input type="checkbox"/>	Reunification	<input type="checkbox"/> Maintain Family
<input type="checkbox"/>	Adoption	<input type="checkbox"/> Live with Relative
<input type="checkbox"/>	APLA	<input type="checkbox"/> AIL
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE)	

For additional children/young adults use Addendum—Additional Children /Young Adults page 3.

DCFS/FINS FRC Referral and Intake Form

Case Name: _____ TIPS # _____ Open Date: _____

ADDENDUM – ADDITIONAL CHILDREN/ YOUNG ADULT

	<input type="checkbox"/> Child #3	<input type="checkbox"/> Young Adult #3
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable) <input type="checkbox"/> Too young <input type="checkbox"/> Expelled <input type="checkbox"/> Suspended <input type="checkbox"/> Pregnant <input type="checkbox"/> Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box): <input type="checkbox"/> Parent(s) <input type="checkbox"/> Specialized Foster Home <input type="checkbox"/> Regular Foster Home <input type="checkbox"/> AFC <input type="checkbox"/> Relative Foster Home <input type="checkbox"/> TFC <input type="checkbox"/> Relative Placement <input type="checkbox"/> Trial Home Visit <input type="checkbox"/> Pre-Adoptive <input type="checkbox"/> Post-Adoptive <input type="checkbox"/> <input type="checkbox"/> Young Adult Setting	
18.	Permanency Goal (If applicable) <input type="checkbox"/> Reunification <input type="checkbox"/> Maintain Family <input type="checkbox"/> Adoption <input type="checkbox"/> Live with Relative <input type="checkbox"/> APLA <input type="checkbox"/> AIL	
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE) _____ _____ _____	

	<input type="checkbox"/> Child #4	<input type="checkbox"/> Young Adult #4
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable) <input type="checkbox"/> Too young <input type="checkbox"/> Expelled <input type="checkbox"/> Suspended <input type="checkbox"/> Pregnant <input type="checkbox"/> Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box): <input type="checkbox"/> Parent(s) <input type="checkbox"/> Specialized Foster Home <input type="checkbox"/> Regular Foster Home <input type="checkbox"/> AFC <input type="checkbox"/> Relative Foster Home <input type="checkbox"/> TFC <input type="checkbox"/> Relative Placement <input type="checkbox"/> Trial Home Visit <input type="checkbox"/> Pre-Adoptive <input type="checkbox"/> Post-Adoptive <input type="checkbox"/> <input type="checkbox"/> Young Adult Setting	
18.	Permanency Goal (If applicable) <input type="checkbox"/> Reunification <input type="checkbox"/> Maintain Family <input type="checkbox"/> Adoption <input type="checkbox"/> Live with Relative <input type="checkbox"/> APLA <input type="checkbox"/> AIL	
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE) _____ _____ _____	

	<input type="checkbox"/> Child #5	<input type="checkbox"/> Young Adult #5
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable) <input type="checkbox"/> Too young <input type="checkbox"/> Expelled <input type="checkbox"/> Suspended <input type="checkbox"/> Pregnant <input type="checkbox"/> Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box): <input type="checkbox"/> Parent(s) <input type="checkbox"/> Specialized Foster Home <input type="checkbox"/> Regular Foster Home <input type="checkbox"/> AFC <input type="checkbox"/> Relative Foster Home <input type="checkbox"/> TFC <input type="checkbox"/> Relative Placement <input type="checkbox"/> Trial Home Visit <input type="checkbox"/> Pre-Adoptive <input type="checkbox"/> Post-Adoptive <input type="checkbox"/> <input type="checkbox"/> Young Adult Setting	
18.	Permanency Goal (If applicable) <input type="checkbox"/> Reunification <input type="checkbox"/> Maintain Family <input type="checkbox"/> Adoption <input type="checkbox"/> Live with Relative <input type="checkbox"/> APLA <input type="checkbox"/> AIL	
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE) _____ _____ _____	

	<input type="checkbox"/> Child #6	<input type="checkbox"/> Young Adult #6
1.	Full Name _____	
2/3/4.	Age/Gender/Rel. to HH _____	
5/6.	DOB/TIPS # _____	
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.	
9.	Parent(s) _____	
10.	Current Caregiver _____	
11.	Current Caregiver Phone # _____	
12.	CASA Name/Phone # _____	
13/14.	Grade/School/College _____	
15.	Reason Child Not in School (If applicable) <input type="checkbox"/> Too young <input type="checkbox"/> Expelled <input type="checkbox"/> Suspended <input type="checkbox"/> Pregnant <input type="checkbox"/> Dropped Out	
16.	Number of Foster Care Placements (If applicable): _____	
17.	Child Living With (check appropriate box): <input type="checkbox"/> Parent(s) <input type="checkbox"/> Specialized Foster Home <input type="checkbox"/> Regular Foster Home <input type="checkbox"/> AFC <input type="checkbox"/> Relative Foster Home <input type="checkbox"/> TFC <input type="checkbox"/> Relative Placement <input type="checkbox"/> Trial Home Visit <input type="checkbox"/> Pre-Adoptive <input type="checkbox"/> Post-Adoptive <input type="checkbox"/> <input type="checkbox"/> Young Adult Setting	
18.	Permanency Goal (If applicable) <input type="checkbox"/> Reunification <input type="checkbox"/> Maintain Family <input type="checkbox"/> Adoption <input type="checkbox"/> Live with Relative <input type="checkbox"/> APLA <input type="checkbox"/> AIL	
19.	Behavior/Disability (TYPE TO END OF LINE; HIT TAB FOR NEXT LINE) _____ _____ _____	

DCFS/FINS FRC Referral and Intake Form

Case Name: _____

TIPS # _____

Open Date: _____

ADDENDUM – ADDITIONAL ADULTS

F. Adult #3	
1.	Full Name _____
2/3/4.	Age/Gender/Rel. to HH _____
5/6.	DOB/TIPS # _____
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
9.	Marital Status _____
10.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Physical Address _____
12.	City/State/ZIP _____
13.	Phone/Alternate Phone _____
14/15.	Emergency Contact _____ <small>Name/Phone</small>
16.	Educational Level _____
17.	Employer Name _____
18.	Special Circumstances (check all that apply.) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Violent Potential <input type="checkbox"/> Disability <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Criminal Record <input type="checkbox"/> Homicidal <input type="checkbox"/> Substance Use/Abuse <input type="checkbox"/> Suicidal <input type="checkbox"/> Trafficking Victim <input type="checkbox"/> LGBTQ Issues <input type="checkbox"/> Other: _____
19.	Does this person have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Is there a Protective Order in place for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No

F. Adult #4	
1.	Full Name _____
2/3/4.	Age/Gender/Rel. to HH _____
5/6.	DOB/TIPS # _____
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
9.	Marital Status _____
10.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Physical Address _____
12.	City/State/ZIP _____
13.	Phone/Alternate Phone _____
14/15.	Emergency Contact _____ <small>Name/Phone</small>
16.	Educational Level _____
17.	Employer Name _____
18.	Special Circumstances (check all that apply.) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Violent Potential <input type="checkbox"/> Disability <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Criminal Record <input type="checkbox"/> Homicidal <input type="checkbox"/> Substance Use/Abuse <input type="checkbox"/> Suicidal <input type="checkbox"/> Trafficking Victim <input type="checkbox"/> LGBTQ Issues <input type="checkbox"/> Other: _____
19.	Does this person have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Is there a Protective Order in place for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No

F. Adult #5	
1.	Full Name _____
2/3/4.	Age/Gender/Rel. to HH _____
5/6.	DOB/TIPS # _____
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
9.	Marital Status _____
10.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Physical Address _____
12.	City/State/ZIP _____
13.	Phone/Alternate Phone _____
14/15.	Emergency Contact _____ <small>Name/Phone</small>
16.	Educational Level _____
17.	Employer Name _____
18.	Special Circumstances (check all that apply.) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Violent Potential <input type="checkbox"/> Disability <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Criminal Record <input type="checkbox"/> Homicidal <input type="checkbox"/> Substance Use/Abuse <input type="checkbox"/> Suicidal <input type="checkbox"/> Trafficking Victim <input type="checkbox"/> LGBTQ Issues <input type="checkbox"/> Other: _____
19.	Does this person have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Is there a Protective Order in place for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No

F. Adult #6	
1.	Full Name _____
2/3/4.	Age/Gender/Rel. to HH _____
5/6.	DOB/TIPS # _____
7/8.	Race/Ethnicity _____ <input type="checkbox"/> Non-Hisp. <input type="checkbox"/> Hisp. <input type="checkbox"/> Unk.
9.	Marital Status _____
10.	To participate with FRC <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Physical Address _____
12.	City/State/ZIP _____
13.	Phone/Alternate Phone _____
14/15.	Emergency Contact _____ <small>Name/Phone</small>
16.	Educational Level _____
17.	Employer Name _____
18.	Special Circumstances (check all that apply.) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Violent Potential <input type="checkbox"/> Disability <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Criminal Record <input type="checkbox"/> Homicidal <input type="checkbox"/> Substance Use/Abuse <input type="checkbox"/> Suicidal <input type="checkbox"/> Trafficking Victim <input type="checkbox"/> LGBTQ Issues <input type="checkbox"/> Other: _____
19.	Does this person have prior involvement with DCFS? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Is there a Protective Order in place for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No