CFS 507
Rev. 7/2013

Caseworker Name: _____

Caseworker Phone: _____

Caseworker Fax: _____

State of Illinois
Department of Children and Family Services

DCFS RESOURCE REFERRAL FORM

(1) **Name of requested provider:** _____ Contract #: _____

Provider address: _____

_____

Phone #: _____

(2) **Service (Check one):** ☐ Visitation ☐ Habilitation ☐ Transportation (for appointments)

☐ Parent Training ☐ General Counseling ☐ Sexual Abuse Counseling ☐ Pre-Adoption Counseling

☐ Hearing Impaired Interpreter ☐ Language Interpreter ☐ Mentoring/Advocacy ☐ Toxicology

☐ CSBP ☐ Adult Sexual Perpetrator ☐ Therapeutic Counseling Services

☐ Other (Specify): _____

Service is Court Ordered: ☐ No ☐ Yes (If yes, attach Order)

(3) **Client name (Head of household):** _____

Address: _____

_____

DCFS Open **CYCIS** Family ID# (Ends in 00): _____ RSF Code: _____

(4) ☐ **Initial Referral** ☐ **Revision** ☐ **Extension/Continuation**

For ***this*** referral, _____ = Maximum total number of hours/units requested per **MONTH**

Requested start date: _____ Anticipated stop date: _____

(No more than 6 months may be authorized; note hour caps on page 4.)

Anticipated date of DCFS case closing: _____

(5) **Name of referred client:** _____

Referred client DCFS **CYCIS** ID#: _____ Medicaid#/RIN: _____

Client Address: _____

_____

Work phone: _____ Home/Cell phone: _____

(6) **Other persons who will be involved (Explain/describe):**

Client name (Head of household): _____

(7) Involved children	D.O.B.	Ward	CYCIS ID#	906 Code	Current Address	Phone

(8) **Permanency Goal for above children who are wards:**

Targeted Achievement Date: _____

Next court date: _____ Type of hearing: _____

(9) **Special communication needs and/or instructions to the provider:**

(10) **Describe, in detail, the service(s) to be provided and the problem areas the service(s) will address:**

(11) **Documentation that is ATTACHED to this referral:** ☐ Family Service Plan ☐ CANTS materials

☐ Medical ☐ Legal ☐ Integrated Assessment ☐ Mental Health ☐ CIPP Action Plan

☐ CERAP ☐ Release of Information ☐ Other (Specify): _____

or PROMISED by (Enter date): _____ ☐ Family Service Plan ☐ CANTS materials

☐ Medical ☐ Legal ☐ Integrated Assessment ☐ Mental Health ☐ CERAP

☐ Release of Information ☐ Other (Specify): _____

Client name (Head of household): _____

(12) **For all VISITATION requests, answer the following questions:**

Visits between parent(s) and child(ren) will be _____ (e.g., weekly; 2x/mo; monthly; etc.)

If applicable, explain why there will be more than one visit per week:

The distance involved from the living arrangement to the visit site is _____ miles.

What extraordinary time and or mileage will be involved?

* * * * * * * * **Service Request Signatures** * * * * * * * *

Assigned caseworker: _____ Date: _____

Desk phone #: _____

Caseworker's supervisor: _____ Date: _____

Desk phone #: _____

* * * * * * * * **Service/Payment Authorization Signature(s)** * * * * * * * *

Approved Provider: _____

_____ = Maximum total number of hours/units authorized per **MONTH**

Approved start date: _____ Stop date: _____

(No more than 6 months may be authorized; note hour caps on page 4.)

Resource/Gatekeeper: _____ Date: _____

ID #: _____

Desk phone #: _____

Resource Manager: _____ Date: _____

(as needed)

Desk phone #: _____

Distribution:
1) Provider (Hard Copy)
2) Case File (Hard Copy)
3) Contract Monitor (Electronic Copy)

Client name (Head of household): _____

IMPORTANT NOTE 1:

Requested services may not begin until the Resource/Gatekeeper signature has been obtained and provider has a hard copy of the approved form. E-mail from each person below is considered an *electronic signature*, and is acceptable. This service is only authorized for the time frame specified, or until the authorized number of hours is used -- whichever occurs first and cannot exceed six months of time per request. Provider may only serve open cases. Provider may bill for the first day a case is opened, but cannot bill on the day the case is closed. DCFS worker must submit a revised request form whenever a change in authorized number of hours occurs.

IMPORTANT NOTE 2:

DCFS *gatekeeper* should **not** authorize **more than**:

- 20 hours/month for Visitation for 1 child or sib group for 1 weekly visit . . . or,
- 20 hours/month for Habilitation . . . or,
- 12 hours/month for Transportation to appointments . . . or,
- 5 hours/month for 1 case for 1 weekly Counseling appointment . . .

without supporting documentation (i.e., an ***Hours Worksheet***).

IMPORTANT NOTE 3:

1) Provider must not exceed authorized number of hours per month:

   a. Provider should track number of hours expended each month and promptly initiate discussions with DCFS if hours are projected to exceed the authorized limits.
   b. Provider should include actual *start & stop* times and related *mileage* on case notes submitted to DCFS caseworker.
   c. DCFS worker will review service *start & stop* times and related *mileage* on monthly case notes for improprieties.

2) Provider should ensure that mileage begins and ends at Office Headquarters, unless doing otherwise would entail less mileage and be more *cost efficient*.

3) Provider should submit a written request and rationale for additional hours of service (extension request) in ADVANCE of the depletion of the currently authorized number of service hours.

   a. DCFS must approve, in writing, submitted rationales for extensions before services may continue.
   b. Upon approval, DCFS worker should submit another referral, with the *Extension* box checked on page 1.