CFS 1448-E
6/2015

State of Illinois
Department of Children and Family Services

Extended Family Support Program Intake Protocol
Needs Assessment

Provider: _____ Referral Date: _____

Client: _____ SCR ID#: _____

Reason Services Were Requested

- ☐ Parent's whereabouts are unknown
- ☐ Parent is deceased
- ☐ Parent is incarcerated
- ☐ Parent is physically and/or mentally unable to care for the children
- ☐ Parent's substance use diminishes their capacity to care for the children
- ☐ Other: _____

Services Requested

	Service Date	
☐	_____	Assistance obtaining guardianship
☐	_____	Assistance enrolling my relative's child in my local school district
☐	_____	Assistance obtaining the IDHS child only grant
☐	_____	Assistance obtaining daycare
☐	_____	Assistance obtaining medical benefits, SNAP or other entitlements
☐	_____	Assistance obtaining beds for my relative's child
☐	_____	Assistance obtaining dressers, clothes or other items for my relative's child
☐	_____	Assistance obtaining adequate housing
☐	_____	Assistance obtaining counseling for my relative's child
☐	_____	Assistance obtaining assistance from kinship support groups
☐	_____	Assistance obtaining IDOA services for Older caregiver
☐	_____	Provide list of service providers in area
☐	_____	Referral for community services: _____
☐	_____	Other: _____
☐	_____	Other: _____

Please have the client read the following:
"I have received a copy of the EFSP brochure and understand the services offered.

_____ _____
Client Signature Date

Caseworker: _____ Phone #: _____

Supervisor: _____ Phone #: _____

"We, the caseworker and supervisor, have not altered this form after the client signed it except to enter service dates and our contact information in the space provided above and our signatures below."

_____ _____
Caseworker Signature Date

_____ _____
Supervisor Signature Date