State of Illinois

Department of Children and Family Services

**Intact Family Service Extension Request**

**Case Information**

Family Case Name:

CYCIS CASE ID:       CYCIS Case Open Date:

Current Service Tier (Enter an “X”):

      Tier 1 open 6 months

      Tier 1 open 12 months

      Tier 2 open 12 months or longer

Tier Effective Date:

**Case Assignment Information**

Agency Name:       Date Request Submitted:

Case Supervisor Name:       (Requests are submitted only by the case supervisor)

Location of Team (City):

**Service Extension Being Requested** (Enter an “X” in the appropriate space)

      Extension of services to more than **6** months after the date of case opening because the family service plan objectives have not as yet all been achieved.

      Extension of services to more than **12** months after the date of case opening because the family service plan objectives have not as yet all been achieved.

Exclusions for Review:

      Court involved. Docket number and date of filing:

      Closing within 30 days. Date of expected closure:

      New baby due in family within 60 days

For above circumstance provide brief current case status:

**Service Extension Request Justification:**  (Please concisely describe the current status of safety factors, risk factors and other clinical issues that created the family’s need for intact family services, and why the factors or issues have not been satisfactorily resolved.)

Reason for case opening: (What were the presenting issues for which there was Department involvement?)

Safety Factors (Describe the safety factors that are not resolved and the services being provided to address the unresolved safety factors.)

Risk Factors: (Describe the risk factors that are not resolved and the services being provided to address the unresolved risk factors.)

Clinical Issues: (Describe the clinical issues that are not resolved and the services being provided to address the clinical issues.)

Other Justification for Extension Request: (Describe any other reason or justification for requesting an extension of intact family services to the family.)

Current frequency of contact with family Each Month:

Expected Closing Date:

Agency Recommendation and Rationale:

|  |  |
| --- | --- |
| **Office of Intact Family Services Review Results** | |
| Date Request Received: | Date Request Reviewed: |
| Name of Reviewer: | Role/Title of Reviewer: |
| Recommendation of Reviewer: | |
| Continue as requested       Schedule staffing       Recommend court filing | |
| Recommend applying for Tier 2 | |
|  | |
| Justification for Recommendation: | |
| Date and time for staffing: | |
|  | |
| **Office of Intact Family Services Statewide Administrator Review** | |
| Date Recommendation Submitted to Statewide Administrator, Office of Intact Family Services: | |
| Summary of staffing/outcome: | |
| Follow-up date for recommended actions: | |
| **Name of the Statewide Administrator:** | |
| **Signature of the Statewide Administrator:** | |