State of Illinois

Department of Children and Family Services

**Family Advocacy Center Referral Form**

**(CFS 600-3 must accompany this referral)**

**All referrals should be emailed to: DCFS.FACReferrals@illinois.gov**

Client Name:       Birthdate:

MARS/CYSIS ID:       RSF:       Phone Number(s):

Address:       City:       State:       Zip Code:

Email:       Language:

Caseworker Name:       Phone:       Email:

Supervisor Name:       Phone:       Email:

Court Involved: Yes  No  Pending Court Date: Click or tap to enter a date. Type:

Referral Source: DCP  Intact  Placement  Other

Date of Referral: Click or tap to enter a date.

Service(s) Requested:

Attachments: CFS 600- 3 Consent for Release of Information  Family Service Plan  **Redacted** CANTS materials  Medical  Court Orders  Integrated Assessment  Mental Health  CIPP Action Plan  CERAP

Active Safety Plan  Visitation Plan  Other Legal Documentation  Other: Click or tap here to enter text.

Household Member: Click or tap here to enter text. Birthdate: Click or tap to enter a date.

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Please provide a detailed summary that includes the current situation, and known strengths and needs of the family or client being served, any safety concerns and special needs. Enter your summary below as well as any additional household members:

Click or tap here to enter text.