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.