



Credentialed Provider Referral Form

GENERAL DCF INFORMATION		
Referral Date:	Referring Office:	DCF Region:
Referring worker:	Phone:	Email:
DCF Supervisor:	Phone:	Email:
DCF Link #:	DCF Child Link#:	Fax:

CREDENTIALLED SERVICE INFORMATION		
Requested Service Type:		
<input type="checkbox"/> Assessment (C/Y) <input type="checkbox"/> Supervised Visitation <input type="checkbox"/> CHAP Case Management <input type="checkbox"/> After-School (Clinical k-7)	<input type="checkbox"/> Assessment (DV) <input type="checkbox"/> Support Staff <input type="checkbox"/> After School (k-7) <input type="checkbox"/> After School (clinical 8-12)	<input type="checkbox"/> Temporary Care <input type="checkbox"/> Therapeutic SS <input type="checkbox"/> After School (8-12) <input type="checkbox"/> Transportation
Service Fees:	Assessment (C/Y) - TBD by AO Supervised Visitation - \$45/hr CHAP CM: \$42/hr After School (t): \$182/wk up to 30 hrs. Flat vacation rate is \$364	Assessment (DV) - \$80-100/hr Support Staff - \$35/hr up to 5 hrs per wk for 6 mo. Transportation - School: TBD After School(c): \$295/wk up to 30 hrs. Flat vacation rate is \$450
		Temporary Care - \$24/ hr Therapeutic SS: \$40/hr up to 8 hrs per wk for 6 mo. Transportation - Other: TBD
Hours of Service Requested: _____ Length of Time Service is Requested: _____		
Is Transportation needed as part of this service? (Y/N)		

FAMILY INFORMATION		
Family Case Name:	Mother's Name:	Father's Name:
Mother's Address	Father's Address:	
How many children are in the household?	Who is requiring this service? (child, children, parent, etc.)	DCF Case Status:
What is the DCF Case Plan Goal for this family?		
What are the Critical Family Needs?		
What are the Family Strengths?		
What are the Safety Concerns?		
What outcome (s) would DCF like to see from the utilization of this service?		



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IS THE PARENT/CHILDREN RECEIVING OR NEED OF THE FOLLOWING SERVICES?		
Check all that apply and indicate/estimate when the service began	Receiving	Need
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Individual Therapy/Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Trauma-focused CBT (TF-CBT)	<input type="checkbox"/>	<input type="checkbox"/>
Child FIRST	<input type="checkbox"/>	<input type="checkbox"/>
Multi-Systemic Therapy (MST)	<input type="checkbox"/>	<input type="checkbox"/>
Family Based Recovery	<input type="checkbox"/>	<input type="checkbox"/>
Triple P or other Parent Education Service	<input type="checkbox"/>	<input type="checkbox"/>
Home Visiting (e.g. Nurturing Families)	<input type="checkbox"/>	<input type="checkbox"/>
Vocational/Employment Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Head Start	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>
Supervised Visitation	<input type="checkbox"/>	<input type="checkbox"/>
Family Reconnection Services	<input type="checkbox"/>	<input type="checkbox"/>
Zero to Three Program-newer program used more frequently in the New Haven/Milford/Bridgeport area offices	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>



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CHILD GENERAL DEMOGRAPHICS							
Name	Gender	Race	DOB	Placement Type	Address	DCF Status	School/Childcare Provider
1							
2							
3							
4							
5							

CHILD SPECIFIC DEMOGRAPHICS					
Name	Current Diagnosis (s)	Current Medications	Reg / Special Education?	Child Strengths	Child Safety Concerns
1					
2					
3					
4					
5					