

Families First Purchase Service Authorization and Referral Department of Juvenile Justice

Part 1

Service Code	Service Description	Rate	Unit	Units Authorized
FFS	Families First Services <input type="checkbox"/> Initial Authorization <input type="checkbox"/> Extension <i>Initial authorization is 196 units. Extension units are negotiated with provider.</i>	\$25.00	¼ Hour	196
Case Type	Court Ordered <input type="radio"/> PSS <input type="radio"/> SCF (only if placement type is BOH)	Non Court Ordered <input type="radio"/> PSC <input type="radio"/> PAT		Case Number
Service Start Date		Service End Date		
Caseworker Signature		Supervisor Signature		Date
Region/Contract Approval Designee Signature		Families First Representative Signature		Date
Caseworker Name		Cell Phone	Caseworker Email	
Office	Office Address		Office Phone	
Supervisor Name		Phone	Supervisor Email	
Region Designee Name		Phone	Region Designee Email	

Part 2 (Part 2 must be filled out completely for initial referral. Part 2 is not required for extension.)

Family Information				
Referred Youth		Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City	State	Zip Home Phone
What is the family's primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				
<i>(Please check [✓] if person is living in referral home)</i>				
<input type="checkbox"/> Mother:	Date of Birth:		Contact Phone:	
<input type="checkbox"/> Father:	Date of Birth:		Contact Phone:	
<input type="checkbox"/> Step Parent or Guardian	Date of Birth:		Contact Phone:	
<i>List all children in home by age</i>				
Name	Age	Date of Birth	School (if applicable)	
Other people in home				
Name	Date of Birth		Relationship	

DCFS caseworker has explained the Families First program to the parent/guardian before submitting this referral. The parents understand that the Families First program will typically require participation for 8 weeks or more and a minimum of 8 hours per week (four 2-hour sessions are common). Schedule adjustments may be made in a given week for family situational issues. Services become less intensive as referral issues improve/stabilize. Yes No

Family Schedule

Work: Mon: _____ Tue: _____ Wed: _____ Thu: _____
 Fri: _____ Sat: _____ Sun: _____

Planned Vacation: _____

Where is the child living at the time of this referral? _____

If the child is not in the home, can he/she be returned home within 7 days? Yes No

Please explain: _____

Problem Checklist: (Please mark with an (x) any of the following problems that you think the family/child is experiencing. Also, please identify persons involved and provide a description regarding the degree of the problem in the space below.)

Continuing Problems - Family

Contributing Problems - Child(ren)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AB Abuse/exploitation by non-family member | <input type="checkbox"/> NG Neglect | <input type="checkbox"/> AA Alcohol abuse | <input type="checkbox"/> MI Mental/emotional illness |
| <input type="checkbox"/> DA Parent drug/alcohol problem | <input type="checkbox"/> PA Physical abuse by parent | <input type="checkbox"/> BP Behavior problems/ delinquent | <input type="checkbox"/> MR MR/DD |
| <input type="checkbox"/> EA Emotional abuse by a parent | <input type="checkbox"/> PC Parent-Child conflict | <input type="checkbox"/> CC Custody change | <input type="checkbox"/> PG Pregnancy/unwed |
| <input type="checkbox"/> FV Family violence | <input type="checkbox"/> RS Parent too restrictive/protective | <input type="checkbox"/> DP Depressed | <input type="checkbox"/> RW Runaway |
| <input type="checkbox"/> IL Parent handicap/illness | <input type="checkbox"/> SA Sexual abuse by parent | <input type="checkbox"/> DR Drug abuse | <input type="checkbox"/> SP Suicide potential |
| <input type="checkbox"/> IR Inadequate physical resource | <input type="checkbox"/> UE Parent unemployment | <input type="checkbox"/> HH Health problem/handicap | <input type="checkbox"/> SX Sexual acting out |
| | | <input type="checkbox"/> LD Learning disability | <input type="checkbox"/> TR Truancy |

Please explain: _____

PRA Risk Level: _____

Identified Risk Factors: _____

What do you expect the Families First Specialist to accomplish (e.g. improve parenting skills, child consequential thinking, increase positive communication, etc., including UFACET items and protective factors that the service is intended to address)?

*****Please attach the full PRA as well as the Needs Assessment Service Plan along with any other documents identifying family needs. If these are not yet available, please make a note explaining that here.**