CFS 968-54A
Rev. 7/2003

State of Illinois
Department of Children and Family Services

System of Care (SOC) Referral Form

Directions: This form must be completed by the child's caseworker to begin the SOC referral process.

Date of Referral: _____ **LAN of Placement:** _____

Child Information

Name: _____ **Child ID:** _____ **DOB:** _____ **Gender:** _____

Child Primary Language: _____ **Date of DCFS Case Opening:** _____

Foster Parent(s) Name(s): _____

Foster Parent Address _____ **Zip Code** _____

Foster Parent Phone: _____ **Foster Parent Primary Language:** _____

Caseworker Agency: _____ **Caseworker Name:** _____

Caseworker Agency Address: _____

Caseworker Phone: _____ **Caseworker Fax:** _____

Supervisor Name: _____ **Supervisor Phone:** _____

Current Setting:

- ☐ POS Traditional/HMR Foster Home
- ☐ POS Specialized Foster Home
- ☐ DCFS Foster Home
- ☐ Home of Parent
- ☐ Emergency Shelter
- ☐ Instituion/Group Home
- ☐ Hospitalization due to medical condition
- ☐ Psychiatric Hospitalization
- ☐ Other, Specify Setting: _____

Prior Services (last year):

- ☐ Counseling/Therapy
- ☐ Psychological Assessment
- ☐ Substance Abuse Treatment
- ☐ Speech/Occupational/Physical Therapy
- ☐ Recreational (i.e., memberships)
- ☐ Medical Assessment/Treatment (beyond routine care)
- ☐ Special Educational Services
- ☐ SASS
- ☐ Tutoring
- ☐ Respite
- ☐ Mentoring

If requesting SOC services because the child is stepping-down, please indicate the following:

Future setting: _____ *Expected Step-Down Date:* _____

14 Day Notice of Placement Change has been Issued: ☐ Yes ☐ No

Briefly describe the presenting issues that have caused you to seek assistance from SOC, and state specifically what you are seeking from SOC (pertinent documentation may also be attached). Include why the referral is being made now: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Caseworker Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

SOC Provider: _____ ***Child Name:*** _____ ***Child ID:*** _____

FP Phone Number(s)		**Best Time to Call**			**Check Available Days**
FP Work:	Beginning:	am/pm	End:	am/pm	☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S
FP Home:	Beginning:	am/pm	End:	am/pm	☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S
FP Other:	Beginning:	am/pm	End:	am/pm	☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Additional Information Requested

- ❑ **DCFS Client Service Plan**
- ❑ **Psychological Assessments -- Type:** _____
- ❑ **Additional Collateral Information -- Type:** _____
- ❑ **Counseling Reports—Type:** _____
- ❑ **Initial Social History/Comprehensive Assessment/Addendums**
- ❑ **Release(s) of Information (needed for release of confidential information)**
- ❑ **Other -- Type:** _____

For SOC Staff Use Only: * Additional information collected directly from referring caseworker (i.e., type, frequency of services, etc.):

SOC Disposition

❑ **Acceptance of the referral**

❑ **Refer back to DCFS or foster care agency:** Reason(s) case is being referred back to DCFS or foster care agency, including recommendations for service/intervention:

SOC Worker Signature: **Date:**

After making a disposition decision, the SOC provider must fax this completed form to the referring caseworker within two days of receiving the referral.