RESET

CONTRA COSTA COUNTY
EMPLOYMENT & HUMAN SERVICES
CHILDREN & FAMILY SERVICES BUREAU

Differential Response Path II & After Care Referral Form

Must be completed by the requesting CFS Social Worker and submitted to the Program Manager at the appropriate DR Agency. Note: if CSEC is present or suspected, please complete the **CSEC 04** instead of this form.

Date:	CFS Referral Received Date: CFS Referral ID# or 19-digit case #:
DR Agency: Select provider by region	ATTN: Select Program Manager for appropriate region
Referring CFS SW: CFS SW Email:	CFS SW Desk Number: CFS SW Cell Number:

Referral Type

☐ This DR Referral is for Path II services. The referral is/will be closed.
☐ This DR Referral is for After Care services. The IFS, FM, or FR case is/will be closed.

Mandatory Transition Meeting

Required attendees: CFS Social Worker (or CFS designee), Family, and DR Case Manager.

- Date, time, and location for DR Transition Meeting: _____
- SW proposed the date with the family: ☐YES ☐NO
- SW confirmed the date with the family: ☐YES ☐NO

If SW has a designee who will attend the meeting on their behalf (e.g., a Social Casework Assistant, another SW, etc.), provide designee's name, title, contact number, and email address below:

_____

Parent(s)/Guardian(s) Residing in the Home

Name:	DOB:	Relationship to Child(ren):
Address:		Contact Number(s):
Email Address:	Ethnicity:	Primary Language:

Name:	DOB:	Relationship to Child(ren):
Address:		Contact Number(s):
Email Address:	Ethnicity:	Primary Language:

Children/Youth in the Home

Name	DOB	School and Grade	Ethnicity	Primary Language

Name and relationship of other adults in the home: _____

If applicable, list other services and providers the family is utilizing, e.g., Wraparound, First 5, CalWORKs, etc.
(use separate page if needed)

Family Member(s) Receiving Services	Provider Name and Contact Number	Program/Agency

Child Welfare History/Information

- Prior CFS Allegations: ☐YES ☐NO
- Prior Child Welfare Referrals Investigated: ☐YES ☐NO
- Prior Child Welfare Case(s): ☐YES ☐NO

Safety and Risk Assessment

SDM Risk Assessment Score: _____ *Risk should be Moderate to High. SW must consult with Sup if risk is High to Very High*	SDM Safety Threats?: ☐YES ☐NO	Safety Plan in Place: ☐YES ☐N/A *(if yes, attach to referral)*

Health and Safety Concerns

Domestic Violence ☐YES ☐NO Substance Abuse ☐YES ☐NO	Criminal History ☐YES ☐NO Mental Health ☐YES ☐NO
Environmental/Household Concerns (e.g. communicable diseases, bed bugs in the home, etc.) ☐YES ☐NO *If yes, please mention concerns in the next question*	Pets in the home? ☐YES ☐NO If yes, please state what kind:
Primary Allegation(s): 1) _____ 2) _____ 3) _____	

Briefly describe the events that led to the Differential Response Path II or After Care referred. This should include: 1) safety concerns that brought this family to the attention of CFS; and 2) how DR services/resources would strengthen the family unit. _____

_____

_____

_____

_____

Goals the family will work on with Differential Response *(should be specific, family-centered, and observable)*:

1. _____
2. _____
3. _____

CFS Social Worker Instructions

1. Email completed referral form, copy of the investigative referral and most recent court report (if applicable), and copy of the DR Parent/Guardian Consent Form (DR 05) to designated DR Program Manager.
2. The Transition Meeting must include the CFS SW (or designee), the family, and DR Case Manager. A Transition Meeting is ideally scheduled with the family upon submitting the DR Referral. Otherwise, schedule a Transition Meeting within 48-72 hours of submitting the referral.
3. The CFS SW may close the CFS referral or case after the Transition Meeting has occurred. The DR Agency will email a status update to the SW after the first DR appointment.