



Service Referral to Collaboratives

The purpose of the Collaboratives is to provide a flexible, comprehensive, family-centered, community-based, outcome-driven child and family services delivery system in the District of Columbia. The strengths of families and communities, as well as the effectiveness of public, private, and community partnerships for early intervention, family support, and violence prevention are what make up the successes of this system. There are six Collaboratives that service the eight wards of the District of Columbia and are located in areas where there is a high incidence of abuse and neglect of children. The six Collaboratives have the following four core program service areas:

- FAMILY SUPPORTIVE SERVICES** Family Supportive Services include diverted cases, short term crisis, community general cases, and reunification support and out of home supportive services.
- PARTNERSHIP FOR COMMUNITY BASED SERVICES**
This category consists of the services provided by the Partnership for Community Based Services.
- YOUTH AFTERCARE**
This category consists of case management services that are provided to youth who will be referred to a Collaborative 90 days prior to emancipation from care.
- COMMUNITY CAPACITY BUILDING SERVICES**
This category consists of community engagement, information and referral, and training
Families may be referred to the Collaboratives for the following services:

- | | |
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| <input type="checkbox"/> Emergency assistance | <input type="checkbox"/> Housing referrals |
| <input type="checkbox"/> Crisis intervention | <input type="checkbox"/> Parenting education and training |
| <input type="checkbox"/> Information and referral | <input type="checkbox"/> Family Group Conferencing (FCG) |
| <input type="checkbox"/> Homemaker services | <input type="checkbox"/> Fatherhood engagement |
| <input type="checkbox"/> Financial guidance and skill building | <input type="checkbox"/> Case Management Services |
| <input type="checkbox"/> Employment counseling | |

When submitting referrals please make sure you include a referral form, a consent form, a SDM (CFSA Structured Decision Making Tool), any court documents if available and any plans if available. If you need further information contact Robert Abney at (202)724-7551 or robert.abney@dc.gov.

CASE REFERRAL FORM TO THE COLLABORATIVE

(PLEASE ATTACH CLIENT'S AUTHORIZATION TO REFER AND DISCLOSE PLEASE SUBMIT SINGLE SIDED WITH PAPER CLIPS PLEASE DO NOT STAPLE)

Choose Collaborative: <input type="checkbox"/> Columbia Heights <input type="checkbox"/> East River <input type="checkbox"/> Edgewood/ Brookland <input type="checkbox"/> Far Southeast	<input type="checkbox"/> Georgia Ave./ Rock Creek East <input type="checkbox"/> South Washington/ West River	Referral Origin: <input type="checkbox"/> CPS (Intake) <input type="checkbox"/> In-Home (JW) <input type="checkbox"/> In-Home (TC) <input type="checkbox"/> Out-Of-Home JW <input type="checkbox"/> Out of Home TC <input type="checkbox"/> Adoption <input type="checkbox"/> Other	Type of Referral <input type="checkbox"/> Diversion (CPS Only) <input type="checkbox"/> Short Term Crisis (CPS Only) <input type="checkbox"/> Supportive Case Assistance for Out of Home Cases <input type="checkbox"/> Adoption	Reason for Referral: <input type="checkbox"/> Emergency assistance <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Information and referral <input type="checkbox"/> Homemaker services <input type="checkbox"/> Financial guidance and skill building <input type="checkbox"/> Employment counseling <input type="checkbox"/> Housing referrals <input type="checkbox"/> Parenting education and training <input type="checkbox"/> Family Group Conferencing (FCG) <input type="checkbox"/> Fatherhood engagement <input type="checkbox"/> Case Management Services	Referral/Case Number: Referral # (Hotline/Intake referral) _____ Case # (Active CFSA case) _____
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I. IDENTIFYING INFORMATION

1. Date of Last Internal or External Case Staffing _____ (attach summary of staffing)
2. Was there an FTM conducted in the last 60 days? (Y/N attach plan)

A. Parent(s) Information	Mother	Father
Name		
Address		
City/State/Zip		
Date of Birth		
Source of Income		
Telephone Number(s)		

B. Children	At Home	Out of Home	Name	D.O.B.	Sex	Address
Insert Total: ___						
Legal Status:						
Legal Status:						
Legal Status:						
Legal Status:						
Legal Status:						
Legal Status:						

C. Caregiver (non-parent)	
Name	

Relationship to Child(ren)	Relative:	Other:
Address		
City/State/Zip Code		
Telephone Number(s)	Home: ()	Work: () Other: ()

CASE ACCEPTANCE SUBJECT TO CLIENT'S WILLINGNESS TO WORK WITH COLLABORATIVE AGENCY
Revised 09/29/2010

II. CFSA INVOLVEMENT

A. Case Information

CFSA Referral Date: _____	CFSA Active Case Open Date (if applicable): _____
Are allegations being supported: _____	Will removed children return home in 90-120 days? _____ (Required for Visitation Service Request)

B. Reason for CFSA Involvement (Current Situation):

1. What was the allegation/reason for investigation?

2. Were the allegations substantiated? (please attach safety risk assessment)

C. Previous Involvement with CFSA and/or Court:

D. Special Conditions

E. Services Requested (Detail what you would like to change to alleviate risk) **CPS ONLY:** URGENT ___Y ___N

F. CFSA Social Worker and Supervisor

Date of Assessment: _____	Date of Referral: _____
CFSA Social Worker: _____	CFSA Supervisor: _____
Email Address: _____	Email Address: _____

CASE ACCEPTANCE SUBJECT TO CLIENT'S WILLINGNESS TO WORK WITH COLLABORATIVE AGENCY
Revised 11/16/2010

Collaborative Program Director/Supervisor/Clinical Coordinator Signature	Telephone #:	Date:	Note: Return copy to Collaborative Liaison Office via email: Shareef.mustafaa@dc.gov
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