

Available "Fee-for-Service":

These services are available for youth in all living arrangements
 Fee schedule and minimum hours may vary

- Trauma-Informed Peer Support Services:**
 - New Referral (average 4 hours/day)
 - Re-Referral/Extension
- Emergency Daytime Care and Other Services**
- Transportation / TAXI Services ONLY:** Call 951-7268 ext 105 at least 3 days prior to need and include detailed instructions on DCF payment approval form

***DCF payment approval form required before start of services**

DCF Contracted Service

Better Horizons Prevention Program
 New Referral (limited availability)
 (DCF worker's referrals for biological homes only; non-DCF referrals may include biological and adoptive homes)
 (Submit referral directly; no DCF gatekeeper)

Child Information

Child's LINK ID number: _____

Child's name: _____ GENDER: M F Date of birth: ____/____/____

In DCF system since _____ Has child disrupted from any placements in the past year? No Yes (circle)

Typical behaviors / personality & clinical / mental health concerns / safety issues (diagnosis, medications, hospitalizations - if any please explain) _____

PLEASE BE AWARE THAT WE DO NOT ADMINISTER MEDICATIONS

DCF Status (circle one)

- | | | | | |
|--|------------------------------|----------------------------------|------------------------------|-------------------------------|
| 01 Dual Commitment (neglected/abused/delinquent) | 04 Committed FWSN | 07 Delinquent Parole Services | 14 TPR Child in Placement | 18 Order of Temporary Custody |
| 02 Committed abuse/neglect/uncared for | 05 Protective Services (CPS) | 08 Voluntary Services | 15 Adoption (Subsidized) | |
| 03 Committed Delinquent | 06 FWSN non-committed | 12 Non-DCF but Prior Involvement | 16 Adoption (Not Subsidized) | 99 Other: _____ |

Caregiver Information

Caregiver name: _____ Issues/concerns in home: _____

Address: _____
Street and Number Town Zip code

Home phone: _____ Work phone: _____ Cell phone: _____

PLACEMENT (circle one): BIOLOGICAL HOME ADOPTIVE HOME GUARDIANSHIP HOME SPECIAL STUDY HOME
 RELATIVE FOSTER HOME FOSTER HOME THERAPEUTIC FOSTER HOME PRE-ADOPTIVE HOME OTHER _____

DCF OFFICE: _____ HARTFORD _____ MANCHESTER _____ NEW BRITAIN _____ OTHER DCF: _____ NON- DCF: _____

DCF SOCIAL WORKER: _____ PHONE: _____ PERSON MAKING REFERRAL

DCF SUPERVISOR: _____ PHONE: _____

FASU WORKER: _____ PHONE: _____

OTHER: _____ PHONE: _____

Person making referral will be contacted upon receipt

Y-US OFFICE USE ONLY

DATE REFERRAL RECEIVED: ____/____/____ DATE SOCIAL WORKER CONTACTED: ____/____/____

START DATE: ____/____/____ DATE FAMILY CONTACTED: ____/____/____