Call (904) 265-8118 to submit referral by phone, Fax referral to (904) 265-6905 or
Submit referral by email to Duval.PreservationIntake@fssnf.org
In email subject line indicate “Safety Management” or “FAST Ongoing”

For cases being referred by phone (265-8118- Family Preservation intake number):

- Caller will hear: for FAST Safety Management or FAST ongoing services Dial 1- or STEPs or HRNB (High Risk Newborn) services Dial 2, and Dial 3 for IPT
- If the caller is seeking FAST Safety Management FSMP (2 hour response time) or FAST ongoing (24 hour response time), when they dial 1, the caller will automatically be sent to intake staff. If this line is not answered, it will go to voicemail that will then instruct the caller to leave case name and number, demographic info, and caller’s contact information. The caller will also be given the option to send an email to Duval.preservationintake@fssnf.org with subject line FSMP or FAST. Specific instruction will be given requesting that the caller be prepared to have important information available to provide to Intake personnel, i.e. safety concern, current address, phone number, social security numbers, birthdates, etc.
- If the caller is seeking information or assistance on an already existing FAST case after 5pm, please contact CMO on-call line. MHRC : 881-0926 JFSC : 759-8040

FAST Ongoing In-Home Services CHECKLIST

1. Ongoing Services Checklist for **Administrative Case Transfer**	
2. FAST Referral Form	
3. Completed FFA	
4. TANF Form	
5. ICWA Form	
7. FAST In-Home Services Agreement	
8. Local Background Check	
9. Signed Safety Plan	
10. Other (CPT Report, Medical Records,etc.)	

Revised 10/23/14

☐ Ongoing case management
72 hr. request

☐ Safety Management

Call (904) 265-8118 to submit referral by phone, Fax referral to (904) 265-6905 or
Submit referral by email to Duval.PreservationIntake@fssnf.org
In email subject line indicate "Safety Management" or "FAST Ongoing"

FAST REFERRAL FORM

Referral Date:		Phone number of person referring	
Referred By Individual:(Name/Title)		DFC Name & Email of Supervisor	

Two times CPI and Family are available for Joint Home Visit that will initiate the FAST Safety Management Phase (FSMP): Option 1) _______________ Option 2) __________________

CLIENT AND FAMILY INFORMATION

Parent/Caregiver/Adult Name: ______________________________

SSN#: ____________ DOB: ____________ Race: ____________

Relationship to Children: ____________ Marital Status: ____________

Parent/Caregiver/Adult Name: ______________________________

SSN#: ____________ DOB: ____________ Race: ____________

Relationship to Children: ____________ Marital Status: ____________

Address: ____________________ Apt/Lot: ________ Zip: ________

Home Phone: ____________ Work or Cell Phone: ____________

Child/Children's Name:	DOB	SS#	Race/Gender	School
1.				
2.				
3.				
4.				
5.				
6.				

REASON FOR REFERRAL (Please be detailed)

Number of Priors: ____________________ **Current FSFN Case ID:** ____________________

Was the child seen by CPT _____ **Yes** _____ **No** **Date:**__________***Must attach CPT report**

Signed Present Danger Plan attached _____ **Yes** **Risk Level Rating** ____________

Or

Signed Safety Plan attached _____ **Yes**

Integrated Practice Team (IPT) REFERRAL FORM

CPI/Worker:	Phone:	Type of Case

PLEASE CHECK Type of Case: Substance Abuse _____ Domestic Violence _____ Adoptions _____

*Please Complete **All** Sections That Apply*

Date of staffing: **Time of staffing:**	**Purpose of Staffing / Needs:**
Case Number:	
Intake Date:	
Date Previously Staffed: / /	

Members in Household:

First, Last *(Check the Box if Attending the IPT)*	Relationship	DOB	SSN	Race/ Gender	Address/ZIP/Phone OR School
☐					
☐					
☐					
☐					
☐					
☐					

Family Background:

Prior Department History:	
Placement History:	
Criminal/DJJ History: ***Felony Convictions*** ☐	
Medical Concerns:	
Mental Health/Behavioral:	
Substance Abuse History:	
Sexual Abuse History:	
Domestic Violence History: ***Referral to Hubbard House*** ☐	
Education History:	
Housing Needs: ***Evictions*** ☐ ***Income*** ☐	

Integrated Practice Team (IPT) REFERRAL FORM

Integrated Practice Team Recommendations and Individualized Action Plan

The persons or agencies listed below have been assigned or agreed to complete the assigned tasks for the _____Family.

A COPY OF THIS PLAN WILL BE PROVIDED TO PARTICIPANTS AND THOSE WHO HAVE TASKS ASSIGNED TO WORK WITH THE FAMILY.

1.

Call (904) 265-8118 to submit referral by phone, Fax referral to (904) 265-6905
Or
Submit referral by email to Duval.PreservationIntake@fssnf.org
In email subject line indicate "STEPS" or "High Risk Newborn"

FAMILY PRESERVATION PROGRAM

☐STEPS
☐High Risk Newborn (Duval County Only)

PLEASE PRINT

Referral Date:	
Referred By Individual:(Name/Title)	
Referral Agency:	
Email:	
Phone # of person referring	
DCF-Name & Email of Supervisor	

CLIENT AND FAMILY INFORMATION

Parent(s)/Caregiver Name: ______________________ ______________________
(Last) (First)

SS#: ______________ Date of Birth: ______________ Race: ______________________

Relationship to Children: ________________ Marital Status: ______________________

Address: ______________________________ Apt/Lot: ______ Zip: ______________

Home Phone: ____________________ Work or Cell Phone: ______________________

Is parent/caregiver currently employed? ___ Yes ___ No
If "Yes," specify where
how long: ____

Parent(s)/Caregiver Name: ______________________ ______________________
(Last) (First)

SS#: ______________ Date of Birth: ______________ Race: ______________________

Relationship to Children: ________________ Marital Status: ______________________

Address: ______________________________ Apt/Lot: ______ Zip: ______________

Home Phone: ____________________ Work or Cell Phone: ______________________

Is parent/caregiver currently employed? ___ Yes ___ No
If "Yes," specify where
how long: ____

Has the family been referred to other community resources? ___ Yes ___ No

If "Yes," specify: ____

____

Child/Children's Name:	DOB	SS#	Race/Gender	School

(Use separate sheet of paper for additional children)

Primary Services Needed

___ In-Home Parenting
___ In-Home Parenting of Teens

___ In-Home Budget Training (STEPS Cases Only)
___ In-Home Behavior Modification (STEPS Cases Only)
___ Case Management only to follow up on referrals completed by CPI (STEPS Cases Only)

Describe the family's needs

# of FSFN Priors: __________ **FSFN Intake #:** ____________________________

Does any member of the family have a violent history? _____ **Yes** _____ **No**

Date CPI opened investigation? _____________

Expected closure date?___________________

Was the child seen by the Child Protective Team? _____ **Yes** _____ **No**
If yes, list the date: __________________ ***Must attach the CPT report**

RISK LEVEL: Low Risk __________ or Moderate Risk __________