**Child Welfare Child Care Services and Early Education**

**Referral and Change for CAPS, Early Head Start, Head Start and Pre-K**

**COMPLETE ONE APPLICATION PER CHILD**

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| Date Submitted: Click here to enter a date. | Date Received by CAPS: Click here to enter a date. | By: Click here to enter text. |
| Type of Action: Choose an item. | Case ID: Click here to enter text. | Legal Status: Choose an item. If DFCS Custody: Choose an item. |
| Type (s) of Service Requested (check all that apply): [ ]  CAPS [ ]  Early Head Start [ ]  Head Start [ ]  Pre-K |
| **Case Manager Information** |
| Name: Click here to enter text. | Title: Choose an item.  | Telephone: Click here to enter text. | Email: Click here to enter text. |
| **Supervisor Information** |
| Name: Click here to enter text. | Telephone: Click here to enter text. | Email: Click here to enter text. |
| **County Director Information** |
| Name: Click here to enter text. | Telephone: Click here to enter text. | Email: Click here to enter text. |
| **Child Information** |
| First Name: Click here to enter text. | MI: Click here to enter text. | Last Name: Click here to enter text. | DOB: Click here to enter a date. |
| SSN#: Click here to enter text. | Gender: Choose an item. | Race: Choose an item. | Ethnicity: Choose an item. |
| US Citizen: Choose an item. | Born in GA: Choose an item. | Legal County (county that has custody): Click here to enter text. |
| Current Educational Status: Choose an item.  | Does child have Special Needs? Choose an item. |
| Does child have and IFSP (Individualized Family Service Plan) or an IEP (Individualized Education Plan)? Choose an item. | If yes, provide the last date updated: Click here to enter a date. |
| **New Placement or New Provider changes MUST be reported to the Scholarship Administration Special Team within 24 hours.****All other changes must be reported within 5 business days.** |
| **Placement Information (If two adult caregivers, provide information for both)** |
| Caregiver Name: Click here to enter text. | Address: Click here to enter text. | Caregiver Status: Choose an item. |
| Home Number: Click here to enter text.  | Work Number: Click here to enter text. | Cell Number: Click here to enter text. |
| Caregiver Name: Click here to enter text. | Address: Click here to enter text. | Caregiver Status: Choose an item. |
| Home Number: Click here to enter text.  | Work Number: Click here to enter text. | Cell Number: Click here to enter text. |
| **Child Care Information** |
| Reason Care Needed: Click here to enter text. | Days Needed: Click here to enter text. | Hours Needed: Click here to enter text. |

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| **Required Items Needed for Referral**  |
| Documents: [ ]  Provider Rate Sheet [ ]  Proof of Citizenship [ ]  Form 602 [ ]  Proof of Activity (CPS) [ ]  Pre-K Referral (If Applicable) |

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| Type of Provider Selected: Choose an item. **Complete Appropriate Section Below Based on Informal/Formal Provider** |
| **Informal Provider** |
| Child Care Provider Name: Click here to enter text.  | Address: Click here to enter text. | Phone: Click here to enter text. |
| Relationship to Child: Choose an item. | DOB: Click here to enter a date. | Location of Care: Choose an item. |
| CRC Completed [ ]  Yes [ ]  No | CPS Screening Completed: [ ]  Yes [ ]  No | Social Service Case Manager Approves Informal Provider?: [ ]  Yes [ ]  No |
| **Formal Provider** |

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| Child Care Provider: Click here to enter text. | Address: Click here to enter text. | Provider ID #: Click here to enter text. |

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| If Change in Provider: Social Service Case Manager Approves?: [ ]  Yes [ ]  No  |  |

**Email COMPLETED Form to** **CAPSReferrals@decal.ga.gov**

**Write Child Welfare Referral in Heading for Referrals and Attach ALL Required Documents**

**Write Child Welfare Change in Heading for Changes and Attach ALL Required Documents**

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| **\*\*\*\*\*\*\*\*\*\*\*\*\*\*Internal Use for CAPS ONLY Below this Line\*\*\*\*\*\*\*\*\*\*\*\*\*\*** |
| **Section I: Document Review** |

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| [ ] All required documentation received. Application submitted for processing[ ]  Application not processed due to: [ ]  Incomplete Referral Form  [ ]  Missing Documentation: [ ]  Proof of Citizenship [ ]  Rate Sheet [ ]  Form 602 [ ]  Pre-K Referral (If Applicable) [ ]  Other Click here to enter text.  |

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| **Section II: Early Head Start / Head Start Determination** |
| Is the child between the age of 6 weeks and 5 years? [ ]  Yes [ ]  No – **If yes, complete Early Head Start / Head Start Section below** |
| If yes, has DFCS Early Childhood Collaboration Manager been contacted for a search of Early Head Start / Head Start? [ ]  Yes [ ]  No  |
| Date Sent: Click here to enter a date.  | Date of Response: Click here to enter a date. | Outcome of Search: Choose an item. |
| Placement: Choose an item. | If Early Head Start or Head Start: Agency Name: Click here to enter text. |
| **Eligibility Determination** |
| Family Unit Size: Click here to enter text. | Rate within DFCS Maximum? : Choose an item. Comment: Click here to enter text. |
| Cost of care if not within Maximum $Click here to enter text. | **Application Disposition:** Choose an item. |
| Has Case Manager been notified of placement? [ ]  Yes [ ]  No | Date Notified: Click here to enter a date. |
| Approving Scholarship Specialist Name: Click here to enter text. | Date of Approval: Click here to enter a date. |

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**Write Child Welfare Referral in Heading for Referrals and Attach ALL Required Documents**

**Write Child Welfare Change in Heading for Changes and Attach ALL Required Documents**