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| --- | --- |
|  | New Referral |
|  | Change Request |
|  | CPS Case Closure Effective: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Social Service Referral for Child Care thru the CAPS Program**

To: (CAPS point of contact) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Customer Name: Phone Number:

Address:

Street City Zip Code

Email address:

**Name and date of birth of children needing Child Care**

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| --- | --- |
| Name | Date of Birth |
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The need for child care must be identified in the CPS case plan. The parental authority with whom the child resides must apply for child care. An application can be submitted online at[**www.compass.ga.gov**](http://www.compass.ga.gov).

1. Is this an open CPS case? Yes or No
2. Is this a CPS diversion case? Yes or No
3. Is this due to a report of a child at risk but Social Service staff are not involved? Yes or No
4. Is the need for child care due to court ordered supervision? Yes or No
5. Is the need for child care in the case plan? Yes or No
6. Is the child(ren) needing care in DFCS custody? Yes or No

Note: If the child(ren) is in DFCS custody Form 57 must be completed by the DFCS Social Service case manager and submitted to the appropriate CAPS point of contact.

1. Have all free child care resources been explored? Yes or No
2. Are free child care resources available for the child(ren)? Yes or No
3. Does the parental authority receive any payment from Social Services (relative subsidy, enhanced relative rate, etc.)? Yes or No If yes, list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Changes**

## All changes should be reported to the CAPS program within 5 days of the change occurrence. The change may affect the eligibility for child care. If not reported timely it could negatively impact payments or terminate child care services through the CAPS program. Please report change(s) below:

Provide any additional comments and/or explanation of extenuating circumstances needing further consideration of child care assistance through the CAPS program below:

SSCM Typed Name: Phone Number:

SSCM Signature: Date: