CFS 1448-C
6/2015

State of Illinois
Department of Children and Family Services

Extended Family Support Program
Case Accepted

Provider: _____ Referral Date: _____

Client: _____ SCR ID#: _____

First Contact Attempt: _____
(Must be within one business day of contact date)

Contact Date: _____
(If more than one day from referral, consult Section 3.3 of EFSP Program Plan

Initial Eligibility Criteria (Must be able to check all boxes)

- ☐ The Provider received referral from DCFS-OHACA
- ☐ The relative caregiver reports to be relative or godparent
- ☐ The child is residing in the home of a relative
- ☐ The relative is providing the primary care for the child
- ☐ The child has been living with the caregiver for more than 14 days
- ☐ The biological parent is not living with the caregiver or cannot care for the child
- ☐ The biological parent does not intend to become caregiver over the next 90 days.

Caseworker: _____ Phone #: _____

Supervisor: _____ Phone #: _____

I have discussed the case with the worker and have reviewed the file and certify that the information on this form is contained in the case file

_____ _____
Supervisor Signature Date