State of Illinois
Department of Children and Family Services

Referral Form

Please check one Referral type and include two copies of all requested documents.

☐ **Life Skills** (Youth in foster care, 14 to 21 Years of Age)

Referral Packets shall include two copies of the following documents:

- ☐ **CFS 912**, **Referral Form** (All requested information must be entered on the completed form.);
- ☐ Face sheet and child specific section of current SACWIS service plan;
- ☐ Integrated Assessment;
- ☐ scored Casey Life Skills Assessment
- ☐ **CFS 600-3, Consent for Release of Information**, signed by the youth and/or authorized agent of the Guardianship Administrator.

☐ **Financial Literacy Education** (Youth in DCFS managed placement, within 30 days of attaining 19 years of age)

Referral Packets shall include two copies of the following documents:

- ☐ **CFS 912**, **Referral Form** (All requested information must be entered on the completed form.);
- ☐ **CFS 600-3, Consent for Release of Information**, signed by the youth and/or authorized agent of the Guardianship Administrator.

Completed referral packets must be submitted to the appropriate Transition Manager of the Office of Education and Transition Services (OETS). Please do not fax life skills referrals.

OETS TRANSITION MANAGERS

Cook Region
OETS Transition Manager
DCFS
6201 S. Emerald Drive
Chicago, Illinois 60621
773-371-6423

Northern Region
OETS Transition Manager
DCFS
8 E. Galena Blvd., Suite 300
Aurora, Illinois 60506
630-801-3446

Central & Southern Region
OETS Transition Manager
DCFS
2309 W. Main Street, Suite 108
Marion, Illinois 62959
618-993-7100

CASEMANAGER DATA

Date:	Name of DCFS/POS Worker:
Worker's R/S/F:	Worker's e-mail address:
Worker's Agency:	
Worker's Address (Street, City, State & Zip):	
Telephone: ( ) -	Facsimile: ( ) -
Supervisor's Name:	Telephone: ( ) -

YOUTH DATA

Youth's Name:	DOB:	Age:
DCFS ID:	Telephone: ( ) -	Cell phone: ( ) -
Youth's Address (Street, City, State & Zip):		
County:	Youth's email address:	
Youth's signature:		

PLACEMENT DATA

Contact Name:	Relationship:
Address (Street, City, State & Zip):	
Home Telephone: ( ) -	Work or Message Telephone: ( ) -
Email address:	

Describe any safety related concerns.

Are there any transportation issues? How will the youth get to classes?

When is the youth available to participate in classes (i.e., Wednesday evenings, Saturday mornings)?

Does the youth have any behavioral/emotional problems? Include clinical diagnosis and medications, if applicable.

What is the youth's learning style? ☐ Auditory ☐ Visual ☐ Participatory

Does the youth have a physical disability? ☐ Yes ☐ No

Type of disability: _____

Date Received:	Approved: ☐ Yes ☐ No	Pended: ☐ Yes ☐ No
	Date _____	Date _____

Assigned Provider:

Signature of Transition Manager: