AB 429 - FAMILY REUNIFICATION (FR)
NOTIFICATION GRAM TO DPSS GAIN SERVICES WORKERS

This form is initiated by the DPSS Linkages GAIN Services Worker (LGSW) in consultation with the DCFS Children's Social Worker (CSW) for new referrals. The Disposition Section and Parts I & II are completed by the LGSW. Part III is always completed by the DCFS CSW when informing DPSS of FR termination **or** requesting an extension.

DCFS 5230 Disposition by the LGSW:

☐ Referral processed as noted below.
☐ Referral not processed; parent not eligible (e.g., undocumented adult, SSI recipient, etc.) to FR because: _____

	Attention: CalWORKs District Office	**Attention: GAIN Region** **(Please see Part II and contact DCFS CSW.)**
Office Name/Number:		
FR Liaison:		
Phone #:		
Email:		

Disposition By LGSW: _____ **Date:** _____

PART I (Please print)

MOTHER'S NAME (Last, First, M.I.)	CASE NUMBER	MOTHER'S PHONE #	MOTHER'S DOB

SELECT ONLY ONE:
☐ All the children listed below were removed from the home.
☐ Partial removal, not all the children were removed. Only the child(ren) listed below were removed from the home.

CHILD'S NAME	DATE OF BIRTH	CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH	CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH	CHILD'S NAME	DATE OF BIRTH

PART II (Please print)

Date: _____

This is to advise you that on _____ the above-cited child(ren) were detained/removed from the home of their parent(s) and it is the plan of the Department of Children and Family Services to provide Family Reunification (FR) Services to the family. I am requesting that your FR Liaison or FR GSW contact me within 3 business days to develop a coordinated service plan pursuant Welfare and Institution Code Section 11203. The plan should include _____ hours/week of DPSS GAIN activities.

The DPSS GAIN activities/services that are recommended/needed are:

☐ Domestic Violence Services for:
  ☐ Legal Services
  ☐ Counseling Services
☐ Substance Abuse Services
☐ Mental Health Services
☐ Job Club/Job Search
☐ Vocational Assessment
☐ Education/Training
☐ Learning Disability Screening
☐ Transportation
☐ Ancillary/Work-Related Expenses
☐ Child Care (If not all children were removed)
☐ Other: _____

Name & Title (CSW): _____ Telephone: _____ e-mail: _____

DCFS Office Name & Address: _____

_____

PART III (Please print) This section is completed by CSW for FR termination or extension only.

Date: _____

☐ This is to advise you that the Dependency Court ordered the termination of Family Reunification Services effective _____. The court ordered the child(ren) to be placed as follows:

Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan
Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan
Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan
Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan
Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan
Child's Name _____	☐ Home of Parent	☐ Into a Permanent Plan

☐ Extension Request for FR Services: The Dependency Court ordered the family continue to receive FR Services. Please contact me within 6 business days to develop a coordinated FR service plan.

Name & Title (CSW): _____

DCFS Office Name & Address: _____ Phone: _____

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