NYC Children's Services

Referral for Child Care and Head Start Services (CCHS)

(THIS IS NOT A VOUCHER)

For Child Care Referral Information, Contact the ACS Child Care/Head Start Family Support/Family Services at **917-228-7076**
For Head Start Referral Information, Contact the ACS Head Start Office at **212-232-0966**
(Sections 1-5 must be completed by the referral source, the person referring the child(ren) for CCHS services)

1. CASE IDENTIFICATION:

State Central Register (SCR) Case Number:

SCR Case Name:

2. TYPE OF REFERRAL *(Check One)*: ☐ New ☐ Reauthorized

☐ Termination/Date of Referral: **MM** **DD** **YY**

3. REFERRAL SOURCE INFORMATION: *(may or may not be the case planner)*

Referral Source (RS) Name:

Agency of RS:

RS Phone: – RS Fax: –

RS E-mail:

Case Planner (CP) Name:

CP Phone: – CP Fax: –

CP Unit Number and E-Mail:

4. FAMILY/CARETAKER INFORMATION:

Caretaker Name *(Last, First, MI)*:

Caretaker Title *(Check One)*: ☐ Birth Parent ☐ Foster Parent ☐ Other:

Home Phone: – Cell: –

Work Phone: –

Street Address: Apt. No.:

Borough, Town Zip Code:

For Child Care and Head Start referrals of children **not in foster care** Caretaker Annual Income:

For **CHILD CARE REFERRALS of children with foster parents** – Is foster parent employed? ☐ Yes ☐ No

NOTE: ***Age Requirement for Head Start -*** *Children ages 3 and 4 are eligible for CS-186D-2 referral. Children who enroll in September through December must be 3 years old by December 31st of the current calendar year.*

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5. CHILDREN NEEDING CHILD CARE AND/OR HEAD START SERVICES:

Child # 1 – Child's Name, Last, First, MI:

Sex: ☐ Male ☐ Female Special Needs or Disabilities: ☐ Yes ☐ No*
Primary Language: Birth Date: MM DD YY

Service Code*: ☐ Child Care ☐ Head Start Elig. Code*: ☐ A ☐ B ☐ C ☐ D
Borough Requirement:

Service Dates**: From: MM DD YY To: MM DD YY (End Date)

Child # 2 – Child's Name, Last, First, MI:

Sex: ☐ Male ☐ Female Special Needs or Disabilities: ☐ Yes ☐ No*
Primary Language: Birth Date: MM DD YY

Service Code*: ☐ Child Care ☐ Head Start Elig. Code*: ☐ A ☐ B ☐ C ☐ D
Borough Requirement:

Service Dates**: From: MM DD YY To: MM DD YY (End Date)

Child # 3 – Child's Name, Last, First, MI:

Sex: ☐ Male ☐ Female Special Needs or Disabilities: ☐ Yes ☐ No*
Primary Language: Birth Date: MM DD YY

Service Code*: ☐ Child Care ☐ Head Start Elig. Code*: ☐ A ☐ B ☐ C ☐ D
Borough Requirement:

Service Dates**: From: MM DD YY To: MM DD YY (End Date)

If requesting service for more than 3 children copy this page and complete as appropriate.

***CODES:** **Service Code:** HS- Head Start or CC- Child Care;
Eligibility Code: A- Preventive/Non-Mandated; B- Preventive Mandated; C- Placement; D- Protective;
Special Needs or Disability: Identify whether or not the child for which services are being requested has special needs and identify what these needs are in the comments section.

** For reauthorization of Child Care services after the end of the service dates, resubmit a CS-186D-2 referral form.

6. AUTHORIZING SIGNATURE

– An authorized person in either Family Permanency Services (FPS) for foster care cases, Family Support Services (FSS) for preventive cases or Child Protective Services (CPS) for protective cases, must verify by signature that the case is active and the services being requested are OR will be part of the Family Assessment Service Plan. The referral source must fax the form as follows: for FSS fax to 718-488-5340, for FPS fax to 212-676-6767. For protective cases, the CPS case manager must sign below. After the authorizing signature is obtained, see section 6 of the instruction form, CS-186D-1- Authorizing Signature Section, for next steps.

Authorized by *(Name and Division)*:

☐ FSS, ☐ FPS or ☐ CPS

Authorized by: *(Signature)*: _____

Phone: – Fax: –

E-Mail:

To be completed by: ***Child Care and or Head Start Staff Specialist***

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7. ENROLLMENT INFORMATION – Complete as applicable

(For child appearing on line #1 of the grid in section 5)

☐ Head Start ☐ Child Care
(please check services being requested)

*Child Care Case Number:

*Child Care Case Name:

Program Name:

Address:

Program Phone Number: –

Program Fax Number: –

Date Services Started: **MM** **DD** **YY**

Children's Services provider agency used ☐ Yes ☐ No *(If no state reason why on line below):*

Child Care/Head Start Staff Specialist Contact Person:

CCHS Staff Specialist Contact Person Phone: –

Child Recertification Date: **MM** **DD** **YY**

(For child appearing on line #2 of the grid in section 5)

☐ Head Start ☐ Child Care
(please check services being requested)

*Child Care Case Number:

*Child Care Case Name:

Program Name:

Address:

Program Phone Number: –

Program Fax Number: –

Date Services Started: **MM** **DD** **YY**

Children's Services provider agency used ☐ Yes ☐ No *(If no state reason why on line below):*

Child Care/Head Start Staff Specialist Contact Person:

CCHS Staff Specialist Contact Person Phone: –

Child Recertification Date: **MM** **DD** **YY**

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(For child appearing on line #3 of the grid in section 5)

☐ Head Start ☐ Child Care
(please check services being requested)

*Child Care Case Number:

*Child Care Case Name:

Program Name:

Address:

Program Phone Number: – –

Program Fax Number: – –

Date Services Started: **MM** **DD** **YY**

Children's Services provider agency used ☐ Yes ☐ No *(If no state reason why on line below):*

Child Care/Head Start Staff Specialist Contact Person:

CCHS Staff Specialist Contact Person Phone: –

Child Recertification Date: **MM** **DD** **YY**

***** Child Care/ Head Start case names and numbers may differ from the SCR case name and number.

IF MORE THAN 3 CHILDREN NEED CCHS, MAKE ADDITIONAL COPIES OF THIS PAGE

CCHS Staff Specialist method of follow-up with referral source *(Phone, fax, e-mail, or other):* _____

Date: MM DD YY

Comments: