# Family Drug Court – Cover Sheet

Client Name(s):________________________________________________

Address: ________________________________________________

Phone Numbers: ________________________________________________

Date Referred to Family Drug Court: ______________________________

Source of Referral: ____________________________________________

Living Arrangements: ____________________(Select from choices below)

1=Homeless – clients with no fixed address; includes shelters
2=Dependent living – clients living in a supervised setting (e.g., halfway house or group home)
3=Independent living – clients living alone or with others without supervision

If Accepted – Date File Opened with Family Drug Court: ____________________

For Referrals not Accepted – Reason not Accepted: ______________________

________________________________________________________________

Children:

| Name | DOB | CASE ID | FACS ID |
|---|---|---|---|
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**Case Conclusion Information**

Date of Court Closure: ______________________________________

Reason for Court Closure: ___________________________________

Date of DHS Case Closure: __________________________________

Self Sufficiency Plan Developed: Yes ___ No ___

**Family Drug Court – Incentives/Sanctions**

Client Name(s):______________________________________________

______________________________________________________

Case ID #(s) ____________________________________________

| Date | Incentive Or Sanction | Description | Precipitating Event | Who Imposed | Completion (Y/N) |
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**Adult Client Service Referral**

Client Name(s):__________________________________________________

____________________________________________________________

Case ID #(s) ___________________________________________________

| Service Category | Assessment Date | Start Date | Brief Service Description | End Date |
|---|---|---|---|---|
| Mental health | | | | |
| Primary Medical Care | | | | |
| Dental Care | | | | |
| Child Care | | | | |
| Transportation | | | | |
| Employment/ Vocational/Educational | | | | |
| Parenting Training/Child Development Ed | | | | |
| Housing Assistance | | | | |
| Continuing Care/ Recovery Support Services | | | | |
| Domestic Violence Services | | | | |
| Other Support Services | | | | |

**Child Service Referral (complete for each child)**

Client Name(s):_______________________________________________

_______________________________________________

Child's Name:_______________________________________________

Case ID # _______________________________________________

| Service Category | Assessment Date | Start Date | Service Description | End Date |
|---|---|---|---|---|
| Developmental services | | | | |
| Primary Pediatric Care | | | | |
| Mental health of counseling | | | | |
| Educational Services | | | | |
| Substance Abuse Prevention and Education | | | | |
| Substance Abuse Treatment | | | | |
| Other Supportive Services | | | | |