CCA-1224A FORFF (3-24)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Child Care

FAST PASS DCS REFERRAL

A Fast Pass Child Care Referral indicates an urgent child care need to ensure safety, prevent removal, or prevent placement disruption. DES waives the income eligibility and DES-required copayment for this child. However, all families will be responsible for charges if a provider's rate exceeds allowable state reimbursement maximums and/or the provider has other additional charges.

ONE FORM / EMAIL PER CHILD

☐ After-Hours ☐ Weekends ☐ Holiday Date: _____

Child care is not provided to (1) Children 13 years of age or older at the time of referral and (2) Children residing in group homes, DDD-licensed homes, or HCTC/Therapeutic foster placements.

CHILD'S INFORMATION

Child's Name *(Last, First, M.I.)*: _____ HLCI Participant Number: _____

Soc. Sec. No. *(optional)*: _____ Birth Date: _____ Sex (M-F): _____ Ethnicity: _____

Does this child have special needs? ☐ Yes ☐ No If yes, indicate the verification provided to you by checking one of the document types listed below.

☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Medical Diagnosis ☐ Other *(explain)* _____

Any unique needs or instructions for this child should be discussed with the child care provider.

CASE INFORMATION

Case Status: ☐ Open/On-Going ☐ Closed at Investigation Case Record Name: _____

DCS Specialist Name *(Last, First, M.I.)*: _____ Phone No. *(include ext.)*: _____

DCS Supervisor Name *(Last, First, M.I.)*: _____ Phone No. *(include ext.)*: _____

CHILD'S LIVING ARRANGEMENT

☐ In-Home Placement ☐ Out-of-Home Placement

Placement Name *(Last, First, M.I.)*: _____

Soc. Sec. No. *(optional)*: _____ Birth Date: _____ Sex (M-F): _____ Ethnicity: _____

Phone No.: _____ Message Phone No.: _____ Language Preference: _____

Address *(No., Street, City. State, ZIP Code)*: _____ Apt #: _____

Mailing Address *(No., Street, City, State, ZIP Code)*: _____ Apt #: _____

☐ ACP-Address Confidentiality Program, ACP Start Date: _____

Other Caregiver allowed to inquire and make changes for this child: _____

PRIMARY REASON FOR CHILD CARE SERVICES

☐ Work ☐ DCS Training/Courts/Staffing/FCRB ☐ School ☐ Socialization ☐ Caretaker Appointments

CHILD CARE PROVIDER INFORMATION

Please check www.azccrr.com to select a DES-contracted child care provider.

NOTE TO CHILD CARE PROVIDER: This referral is approval for the child to attend care. This referral replaces the DES verbal authorization and ensures payment for the child named above. You will receive a Certificate of Authorization for 23P.

Start Date: _____

Child Care Provider's Name: _____ Phone No.: _____

Location Address *(No., Street, City, State, ZIP Code)*: _____

Signature of DCS Specialist completing this form: _____

A copy of this form must be emailed to CCA-DCS-Referrals@azdes.gov on the same day of completion.

Routing: Original-DCS - Yellow Copy-DES Child Care Provider - Pink Copy-Placement/Parent