

**Extended Family Support Program
Case Ineligible**

Provider: _____ Referral Date: _____

Client: _____ SCR ID#: _____

First Contact Attempt: _____

(Must be within one business day of contact date)

Contact Date: _____

(If more than one day from referral, consult Section 3.3 of EFSP Program Plan

Check the Initial Eligibility Criteria not met:

- The Provider did not receive the referral from DCFS-OHACA
- The caregiver is not relative or godparent
- The child is not residing in the home of a relative
- The relative is not providing the primary care for the child
- The child has not been living with the caregiver for more than 14 days
- The biological parent is living with the caregiver and can care for the child
- The biological parent intends to become caregiver during the next 90 days.
- The relative caregiver is no longer seeking services
- Other: _____

Caseworker: _____ Phone #: _____

Supervisor: _____ Phone #: _____

I have discussed the case with the worker and have reviewed the file and certify that the information on this form is contained in the case file

Supervisor Signature

Date