Connecticut Department of Children and Families
THERAPEUTIC CHILD CARE GATEKEEPER FORM
DCF-2190
9/17 (Rev.)

Child's LAST Name:	Child's FIRST Name:	Child's DOB:	Child's PID#:	LINK Case #:

Child's Race:	Child's Ethnicity:	Child's Gender:
Please Select One	Please Select One	Please Select One

Caregiver LAST Name:	Caregiver FIRST Name:	Caregiver E-mail:	Caregiver Phone #:

Caregiver Address (No. and Street):	City:	State:	Zip:

Caregiver Relationship to Child:	Language(s) spoken in home:
Please Select One	Please Select One (or enter your own)

Child's DCF Status:	Is Reunification Plan Permanency? ☐ Yes ☐ No
Please Select One	

DCF SW LAST Name:	DCF SW FIRST Name:	SW E-mail:	SW Phone #:

DCF SW Supervisor LAST Name:	DCF SW Supervisor FIRST Name:	SWS E-mail:	SWS Phone #:

DCF Office: Select DCF Office

Are any of the following risk factors known for this child?	
☐ ABI / TBI	☐ Adult in home abused alcohol or prescription/street drugs
☐ Experienced separation from primary caregiver	☐ Homelessness/unstable living situations
☐ History of Neglect	☐ Parent involved with SDCF/DDS as a child
☐ History of Physical Abuse	☐ Parent with cognitive limitations or serious behavioral health issues
☐ History of Sexual Abuse	☐ Witness to domestic violence or DV is present in the home
☐ Lead Exposure	☐ Other:

Does Child present with any of the following trauma symptoms?	
☐ Aggression toward family, caregivers or peers	☐ Developmentally inappropriate sexual behaviors
☐ Difficulty paying attention/focusing	☐ Disruptive, unsafe, or dangerous behaviors (running away, self-harm, destroys own/other's property)
☐ Excessive irritability	☐ Doesn't speak when developmentally appropriate
☐ Hurst animals	☐ Excessive withdrawal from social interaction
☐ imitating traumatic event during play	☐ Prolonged or extreme tantrums/outbursts. Will tantrum/cry until exhausted
☐ Inability to be soothed or comforted	☐ Terrified responses to sights, sounds, etc. that remind child of the trauma
☐ Sleep /Appetite disturbance	☐ Wild eyes, especially when stressed
☐ Unusually high level of anger/excessive temper	☐ Somatic complaints
☐ Anhedonia (lack of pleasure)	☐ Other:

Expand your reason for referral, including current behavior challenges in early care setting and at home. Describe specific behaviors and family situations:

Describe why typical classroom does not meet child's needs:

Is child currently in an early care setting?: ☐ Yes ☐ No. Is child on any medication(s)?: ☐ Yes ☐ No. If "Yes", please list:

☐ Child's Medical/Diagnostic Information:

Has the child or family received, or is currently receiving. Intervention to address challenging behaviors?:

Birth-to-Three	☐ Yes	☐ No Please select one	If "Yes" for 0-3, has Evaluation been complete?	☐ Yes	☐ No	
Special Ed. Services	☐ Yes	☐ No Please select one				
Child First	☐ Yes	☐ No Please select one	Mental Health Services (Adult)	☐ Yes	☐ No	Please select one
ECCP	☐ Yes	☐ No Please select one	Outpatient Therapeutic Svs.	☐ Yes	☐ No	Please select one
EMPS	☐ Yes	☐ No Please select one	Prenatal Substance Exposure	☐ Yes	☐ No	Please select one
IPV/FAIR	☐ Yes	☐ No Please select one	Substance Use Services	☐ Yes	☐ No	Please select one

ATTACHMENTS to this referral: ☐ Current Family Case Plan ☐ Current Child Case Plan ☐ MDE ☐ Other:

DISPOSITION: ☐ Referral NOT Accepted (See below) ☐ Accepted into TCC:
☐ Referred to other services:
☐ If Referral is NOT accepted, Please explain why:

SUBMIT TO NEW BRITAIN

SUBMIT TO BRIDGEPORT