Incredible Years Completion Report

Department of Children, Youth and Families

Agency: Provider ID: Names of Group Leaders:

Referral Information

Case ID: Name of Parent or Caregiver: Date of Referral:

Caseworker Name: Referring Program: CPS
CPS FAR
FVS
CFWS

Region: Make a Selection Office:

Name of Child: Gender: Person ID:

If known indicate:

☐ Developmental Delay

☐ Behavioral Problems

Diagnosis:

Complete 1 (one) form for each referred participant who participates in the IY course

Name of Parent: IY Parent Group Type: Make a Selection

Number of sessions attended: Did the parent successfully complete the service? ☐ Yes ☐ No

IY Service Summary Attached? ☐ Yes ☐ No

Date sent to DCYF Fiduciary:

Agency Signature

August 2022