



## Community Collaboration for Children

### In-Home Services Referral Form

Email to: Lindsey Conger: [lconger@nkcac.org](mailto:lconger@nkcac.org)

Fax: 859-655-2949

Any questions, please call Lindsey at 859-655-2977

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Date: \_\_\_\_\_

Referral from:  Community Partner  Family  Other

Name: \_\_\_\_\_

Referring Agency, if any, or relation to family: \_\_\_\_\_

Referral source telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

#### **Family information:**

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Who has custody of child(ren)?: \_\_\_\_\_

**\*Child must reside with biological parent or caregiver who has permanent custody or caregivers who do not have an open DPP case.**

Child(ren) Name(s)	Race	Gender	DOB
1.			
2.			
3.			
4.			
5.			
6.			

Family's Address: \_\_\_\_\_

Family's Phone #: \_\_\_\_\_

Family Involved with Cabinet? \_\_\_\_\_

Family aware a referral is being made? \_\_\_\_\_

**Why are In-Home Services needed?**

**Do any of the following apply to the family being referred?**

<b>Concern</b>	<b>Yes, No, Unsure, N/A</b>	<b>Family members involved</b>	<b>Details</b>
<b>-Safety issues</b>			
<b>-Cultural issues</b>			
<b>-Substance use/abuse</b>			
<b>-Domestic Violence</b>			
<b>-Criminal history</b>			
<b>-Home conditions</b>			
<b>-Hygiene</b>			

**Family Strengths:**