



Community Collaboration for Children

Family Team Meeting Referral Form

E-mail or fax to: Lindsey Lilly

lilly@nkcac.org

859-655-2949

Referral from Community Partner
 Family
 Other: _____

Person making referral: _____ Date: _____

Referring Agency: _____

Contact Telephone: _____ E-mail: _____

Family Name (first and last): _____

County family resides in: _____

Meeting Dates and Times (Please list 3 options):

1. _____
2. _____
3. _____

Proposed Meeting Location:

1. _____
2. _____
3. _____

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

Family's Address: _____

Family's Phone #: _____

Family Involved with CHFS? _____

If yes, county and worker: _____

Who has custody of the children? _____

Please list any Safety concerns the facilitator should be aware of:

**Are there other staff or agencies that should be invited to the Family Team Meeting?
If yes, please provide contact information:**