NORTHERN KENTUCKY COMMUNITY ACTION COMMISSION

Community Collaboration for Children

In-Home Services Referral Form

E-mail or fax to: Lindsey Lilly: llilly@nkcac.org
Fax: 859-655-2949
Any questions, please call Lindsey at 859-655-2977

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?

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

Family Strengths: