Central KY. Community Action, INC
CCC IN-HOME REFERRAL FORM

Email to: Ronda Bertrand ronda.bertrand@ckcac.org Questions call: 270-692-7553
CCC Director and Trail of Hope Regional Network Coordinator

Referral Source: DCBS _____ Other _____
Case #: (if applicable)_____
Referring Person/Agency: _____ Phone _____
Supervisor: _____
Supervisor's Signature:_____
Family Name: _____
Home Phone: _____ Other: _____
Address and Directions:
_____
_____
_____

Is Family Advised of the referral to in-home services: Yes_____ No _____
Is the Family Willing to Work with In-Home Services? Yes_____ No _____

Name of Adults in the home	**Relationship**	**Age**	**Race**

Children Names	**Sex/Age/ DOB/Race**	**Social Security #**

Is Court Action Pending? Yes_____ No_____ Type:_____
Is Family Conflict a Concern? Yes_____ No_____
Do we need an FTM prior to opening the case?_ Yes_____ No_____

What are the concerns that need to be addressed with this family? _____
_____
_____
_____
_____

What changes need to occur for the children to be in a more stable environment? _____
_____
_____
_____
_____

Discuss other issues; Safety concerns; family strengths and resources. _____

Are there any other agencies involved with this family? If so please list: _____

Note any other concerns in home staff need to be aware of regarding this family: _____