



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: _____ Other _____
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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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: _____

