**P.A.C.S./FAMILY PRESERVATION PROGRAMS**
**HOME BASED SERVICES**

# REFERRAL FORM

Received Original Referral:_____Accepted:_____Rejected:_____
Family Name: _____ Home phone: _____
Address, Directions:
_____
_____
Is this a self-referral? Yes [ ] or No [ ]
Family advised of referral? Yes [ ] or No [ ]
Name of parent or guardian willing to work with program:
_____
Referring worker: _____
Phone: _____
Date of Referral: _____ County: _____
Supervisor: _____
Supervisor's Evaluation of Placement risk: **High____ Moderate_____ Low_____**
Supervisor's Signature: _____ Date: _____

**ADULTS IN THE HOME:**

| Name | DOB | Age | SSN | Relationship to child |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**CHILDREN IN THE HOME/OUT OF HOME:**

| Name | DOB | Age | SSN | *=Child out of home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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# REFERRAL FORM

Please Note any/all of parent(s) and child(ren) disabilities:

_____
_____
_____
_____
_____

Please Note the education level of the parent(s) and child(ren):

_____
_____
_____
_____
_____

Is court action pending? Yes _____ No_____ Type: _____
Next Court Date: _____

Please describe the current crisis/reason for this referral.

_____
_____
_____
_____
_____

What changes need to occur for the child to remain safely in the home or in their current out of home placement?

_____
_____
_____
_____
_____

Has the child(ren) been placed in out of home care before? If so, please provide a summary of services and results. Include any placement dates.

_____
_____
_____
_____
_____

**Please send referrals to:

MAIL: CCC: HBS(Pennyrile)
P.O. Box 549
Hopkinsville, KY 42240
Phone: 270-707-9735
Fax: 270-707-9737

CCC:HBS (Purchase)
P.O. Box 5180
Mayfield, KY 42066
Phone: 270-247-7072
Fax: 270-247-7880