

Pennyrile Allied Community Services, Inc.

CCC

Supervised Visitation

REFERRAL FORM

Family Name: _____ Case #: _____

Family Address: _____

Family Home Phone: _____ Message Phone: _____

Out of Home Contact Person (foster care, relative placement, etc.): _____

Phone Number of Out of Home Contact Person: _____

Referring DCBS Worker: _____ Date of Referral: _____

Referring DCBS Worker's Phone: _____ County: _____

DCBS Supervisor Signature: _____ Date: _____

ADULTS IN THE HOME:

Name	DOB	Age	SSN	Relationship to child

CHILDREN IN THE HOME/OUT OF HOME:

Name	DOB	Age	* = Child out of home	SSN

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

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

Reason for the referral: Please describe the current crisis/reasons that removed the child(ren) from the home.

Are parents allowed to bring items to the visit for the children (toys, pictures, drinks, food, etc.)?
Please circle your answer.

YES NO

Is yes, please list the restrictions. _____

What restrictions, if any, do you have for the family (such as topics not to be discussed, items, changing diapers, taking children to the bathroom, etc.)?

Are the parents or child(ren) diagnosed with a mental illness or behavior disorder? If so, what?

Please list the goals the family needs to achieve in regards to the child(ren) in order to move towards in-home visits/reunification?

What is the possibility of reunification, with 1 being extremely low and 5 being very high.

1 2 3 4 5

What is the potential for physical abuse within the family?

1) Extreme 2) High 3) Moderate 4) Low 5) None

What is the potential for physical abuse toward others?

1) Extreme 2) High 3) Moderate 4) Low 5) None

PLEASE ATTACH VISITATION AGREEMENT AND PREVENTION PLAN.