YOUTH SERVICE BUREAU
KINSHIP SUPPORT SERVICES REFERRAL FORM

Instructions: Please fill out all sections as completely as possible. **Fax completed referral(s) to: (510) 232-3460**

Date: _____

SECTION 1: Caregiver's Information

Caregiver's Name: _____
Address: _____ City: _____ Zip: _____
Home Phone Number: _____ Cell Phone Number: _____

SECTION 2: Relative Information

Children:

Name:	DOB:	Ethnicity:	☐Male ☐Female
Name:	DOB:	Ethnicity:	☐Male ☐Female
Name:	DOB:	Ethnicity:	☐Male ☐Female
Name:	DOB:	Ethnicity:	☐Male ☐Female

Caregivers:

Name:	Rel. to Child:	DOB:	Ethnicity:	Marital Status:
Name:	Rel. to Child:	DOB:	Ethnicity:	Marital Status:

Others living in the home:

Name:	Rel. to Child:	DOB:	Ethnicity:	☐Male ☐Female
Name:	Rel. to Child:	DOB:	Ethnicity:	☐Male ☐Female
Name:	Rel. to Child:	DOB:	Ethnicity:	☐Male ☐Female
Name:	Rel. to Child:	DOB:	Ethnicity:	☐Male ☐Female

SECTION 3: Reason for Referral

Please describe the events that led to the referral to Kinship Care:

_____

_____

SECTION 4: Services Needed (check all that apply)

□ Basic Needs	□ Parent Education	□ Housing	□ Transportation
□ Food	□ Support Group	□ Case Management	□ Respite Care
□ Health Care	□ Guardianship	□ Recreation	□ Mentoring

SECTION 5: Referral Source Information

Name: _____ Please circle one: CFS School Probate Self Other
Phone Number: _____ Email Address: _____

Case Assignment: KSSP Provider Use Only

Start Date: _____ Kinship Case Worker Assigned: _____
CM: _____ NCM: _____