Kinship Care Referral

Phone# (813) 627-2129
Fax# (813) 200-3996

Completed by Intake Staff

Received: _____
Referred: _____
Agency: _____
Case ID#: _____
FSC Assigned: _____

Date Referred: _____

Referring Person/Agency: _____ **Office Number:** _____
Report # (if applicable): _____ **Cell Number:** _____
If self referral, how did they find out about Kinship? _____ **Email:** _____

I. Reason for Referral (Services requested): _____

II. Services Needed for the Family: _____

III. Family/Child Information: ☐ **SPANISH SPEAKING ONLY**

Caregiver #1:		**Caregiver #2:**	
DOB:		**DOB:**	
Social Security:		**Social Security:**	
Race & Ethnicity:		**Race & Ethnicity:**	
Relationship to child:		**Relationship to child:**	
Cell Phone:		**Cell Phone:**	

Address:		**Home Phone:**	
City:	**Zip Code:**	**Best Time to Call:**	

Child's Name	DOB	Age	Gender	Race & Ethnicity	Social Security	Grade

Other Household Members (Please list names, DOB, relationship, & any other important info**):** _____

IV. Additional Information:
Current/Prior Legal Involvement: _____
Current Referrals/Services: _____
Prior Referrals/Services Known: _____
Medical Information: _____
Other: _____

A person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline or in the records of any child abuse, abandonment, or neglect case, except as provided in this chapter, is guilty of a misdemeanor of the second degree, punishable as provided in s775.082 or s775.083.