

**KENTUCKY RIVER AREA DEVELOPMENT DISTRICT  
COMMUNITY COLLABORATION FOR CHILDREN REFERRAL**

Eligible families are those whose children are in the home, but are at risk for abuse and/or neglect. We are unable to accept referrals for families who are currently involved in domestic violence or substance abuse and are not in treatment and families where the child(ren) is/are at risk of sexual abuse due to continued exposure to the perpetrator.

\*Does the family have an open DCBS Case? Yes  No  If yes, please contact the DCBS social worker to verify that CCC is an appropriate service for the family before making this referral.

Referral for (check all that apply):

In-Home Services

Child Birth to 5 years

**Referral Information:**

1. Family name:

2. Home phone:

Alternative phone or e-mail:

3. Address:

4. County in which family lives:

5. Directions to home:

6. Adults in Home (including client named above):

Name	Sex	DOB	Relationship	SS#

7. Children in the home:

Name	Sex	DOB	Relationship	SS#

8. Are any children in out-of-home placement? Yes  No

If yes, what are the children's names and where are they placed?

9. Amount & Source of Income:

Name	Source of Income	Amount

10. Is Court Action Pending? Yes  No  Next Court Date:

Type of Action:

11. Has Family Been Advised of CCC Referral? Yes  No

12. Date of last worker contact with family: \_\_\_\_\_

13. What puts the children in this family at risk of abuse and/or neglect?

14. What services need to be provided in order for the child(ren) to remain in the home and safe? What issues need to be addressed?

15. The CCC program will be conducting home visits with this family. Please describe any safety concerns that staff should know about before conducting a home visit.

16. Are there CURRENT substance abuse issues in the home? Yes  No

17. Has the family been referred to treatment for substance abuse issues? Yes  No

18. If yes, has the family been referred to: \_\_\_\_\_NA/AA \_\_\_\_\_TAP \_\_\_\_\_Substance Abuse Assessment  
\_\_\_\_\_Substance abuse counseling \_\_\_\_\_Project Advance Other: \_\_\_\_\_

19. Has the family been referred to treatment for mental health issues? Yes  No

20. If yes, which family members have been referred or are undergoing treatment?

\_\_\_\_\_  
\_\_\_\_\_

21. If yes, has the family been referred to: \_\_\_\_\_KRCC \_\_\_\_\_Mental Health Assessment  
\_\_\_\_\_Mental Health counseling Other: \_\_\_\_\_

22. Has your agency developed a case/action/safety plan with the family? Yes  No   
If so, a copy must be attached for referral to be complete.

23. What agencies, including yours, are involved with this family?

Name of Agency	Services Provided	Length of Service

24. Is FPP involved with the family? Yes  No   
If so, when will they end their services to the family?

25. Other Relevant Information/ Comments:

**Referring Agency Information:**

(For DCBS referrals, we will send information via e-mail to the worker, FSOS, and Heather Meade)

26. Referring agency/self referral:

27. Referring Worker: (print name)

28. Referring Worker Signature \_\_\_\_\_ date \_\_\_\_\_

29. Phone: Office: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

30. Preferred method of contact: Phone  E-mail  Other  Explain: \_\_\_\_\_

31. When in the next five days would you be available to go out on a home visit to the family you are referring?  
Please list dates and times for several opportunities.

32. CCC staff will provide follow-up information to you about this family. At what intervals would you like this information provided? Weekly  Monthly  Quarterly  No follow-up needed

33. Date referral form completed: \_\_\_\_\_

Completed referrals should be sent to CCC Supervisor, Deb Dunaway via e-mail at [lkp.ccc@lkp.net](mailto:lkp.ccc@lkp.net) or [d.dunaway@lkp.net](mailto:d.dunaway@lkp.net), fax at 606-439-2229, or mail at 398 Roy Campbell Drive, Hazard, Kentucky 41701. Referrals from DPP staff should be sent to Heather Meade at the Whitesburg office. Questions may be directed to Deb Dunaway at 606-436-3161.

For CCC Program Use Only:

Date referral received:	
Date of referral review:	Supervisor who reviewed referral:
Results of review: Eligible            Ineligible            Hold	Staff Assigned: Date staff received referral