Gateway Longview

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KinCARES Family Support Referral Form

Name of Person Completing Referral _____

Agency _____

Address _____

Daytime Phone _____

Supervisor's Phone _____

Client Information

Date: _____

Name_____

Address _____

City _____ State _____ Zip Code _____

Daytime Phone _____ Evening Phone _____

Best time to call? _____

What is your relationship to the child(ren)?

_____

How many children are you providing care for?

_____

Reason for Referral:

_____

_____

_____

_____

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Is this Kinship placement the result of court involvement or is it informal? Please explain.

_____
_____
_____

How is the child's relationship with their biological parents?

_____
_____
_____
_____

How is the relationship between the child(ren)'s biological parents and kinship caregivers?

_____
_____
_____

What are the current stressors/ needs of the child and kinship family?

_____
_____
_____
_____
_____

Circle the services anyone in the kinship home receives if applicable:

Medicaid	SSI
Food Stamps	HEAP
Family Assistance/Safety Net	School Lunch Benefits

Please mail or fax referrals to:

Gateway Longview
c/o Heather Radzikowski
10 Symphony Circle
Buffalo, NY 14201
Fax: (716) 995-3207
Phone: (716) 783-3181