CALIFORNIA FAMILY LIFE CENTER
KIN CARE REFERRAL FORM

Date of Request: ______________________

Referred by:

□Self	□Parent	□Family Member	□Teacher/Counselor
□Social Worker	□MH Provider	□CFLC Staff	□Other______________________

(If not a self referral): Contact Person__________________________Telephone #:___________________

(If self referral): How did they hear about Kin Care? ____

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CLIENT INFORMATION

Caregiver's Name: ____

Home Phone: ______________Work Phone: _______________Alt. Phone: _____________

Caregiver's Address: __________________________City:__________Zip Code________

Present Status (brief description of family situation; include children's names, ages, and relationship to caregiver):

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Primary Language of the client if other than English: _____________

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For Office Use Only

Name of person taking referral: _________________________________

Will this Caregiver enroll in the Kin Care program? Please circle one:

YES NO

_____Client does not meet program enrollment criteria

_____Client declined appointment or declined to enroll in program

_____Client unresponsive to phone calls, letters

_____Other:_________________________________

Attempted Contact: 1st__________ 2nd__________ 3rd___________

Please fax this referral for to (951) 791-3554.