



Mentoring Referral

Information can be provided by Parent(s)

Date _____

Name(s): A _____

B _____

Address: _____

City: _____ Zip: _____ County of Residence: _____

Parent A

Parent B

Phone #: _____

Phone #: _____

Email: _____

Email: _____

Occupation: _____

Occupation: _____

Age: _____

Age: _____

Information provided by DCBS only

Type of Home

- Foster
 - Foster to Adopt
 - Adopt
 - Relative Care/Fictive Kin
- Relationship to child: _____

Type of Referral

Relative/Fictive Kin Seeking Certification (Attended Informational Meeting) Date of Placement: _____

Newly Approved Home Date Approved: _____ Date of Placement (if applicable): _____

If newly approved, choose one: Basic Basic Relative/Fictive Kin Child Specific

Subsequent Referral

Service Extension

Reason for subsequent referral or extension of current mentoring services:

- Recent First Placement
- Limited Support System
- Potential Disruption
- Placement Disruption
- Home Reopened
- Targeted Support
- Other _____

Current Compatibility Criteria

Preferred Age: _____ Preferred Gender: _____

Preferred Race: _____ Notable Placement Considerations for Behavior (SAFE Comparability Inventory):

R&C Worker's Information

Name: _____ Service Region: _____

Email: _____ Phone: _____

TRC Office Use Only

Mentor Program Personnel: _____ Mentor: _____

Match Pending: _____ **Reason:** _____ **Date:** _____

Match Created: ____/____/____ Anticipated End Date: ____/____/____

Mentor Match Not Created: N/A Declined Services Did Not Respond Date: _____