DATE OF REFERRAL

# KY OOHC Intercept Referral Form

Case Number:

Child's name: DOB: SSN:

Gender Race: Caregiver:

Address: Phone number(s):

County of placement: Region of Placement:

Region of Commitment: County of Commitment:

Service Type: Permanency Plan: Return to parent Adoption Planned Permanent Living Arrangment

PCP Agency: PCP CM Contact Info:

PCP Therapist & Contact Info:

**Service Needs:** (Check all that Apply)

- Suicidal/Homicidal/Psychotic behaviors
- Physical Aggression
- Problematic Sexual Behaviors
- Verbal/Physical Defiance
- Elopement Behaviors
- Exposure to Caregiver/Family Substance Misuse
- Hyper-Independence
- Family conflict
- Survivor of Sexual Abuse
- Youth Substance Use
- Justice Involvement
- Autism or Pervasive Developmental Delay
- Verbal Aggression

Additional information about important events or behaviors not identfied above. For reunification referrals, please include the anticipated date of reunificaiton, name, address, and contact information for the family of removal.

**DCBS STAFF INFORMATION**

| DCBS STAFF | NAME | PHONE # | EMAIL |
|---|---|---|---|
| *SSW | | | |
| FSOS | | | |
| SRCA | | | |
| SRAA | | | |
| R&C | | | |