HOPE for all seasons

Catholic Charities Kinship Caregiver Program Referral Form

*Note for the family to be referred to the program the child **MUST** be eligible for TANF/Public Assistance Cash Assistance

Primary Relative Caregiver Name: _____

Primary Relative Caregiver's Relationship to Child: _____

Address of Family:

_____

Street Address City/Town State Zip Code

Home Phone Number: _____ Other Contact Number: _____

Email address:_____

Child Name: Date of Birth:

1. _____ _____

2._____ _____

3. _____ _____

4. _____ _____

5. _____ _____

Is the Child Currently Receiving TANF (Temporary Assistance for Needy Families) or Public Assistance:
Yes No Don't Know

Cash Assistance: Yes No Don't Know

TANF/Public Assistance Worker's Name and Phone Number: _____

PA Number:_____

Reason the Child is living with Relative Caregiver: _____

_____

_____

_____

How long has the Child resided with Relative Caregiver? _____

Is there an expectation that the child will return home to parents: Yes No

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Circle Needs of Family:

Legal	Parenting Skills and Support	Family Issues	Child Care
Financial	Stress Management	Employment	Housing
Adoption	Special Needs (Disability)	Mental Health	Medical

Comments:_____

_____

_____

_____

_____

Referral Source Name and Phone Number: _____

Please use space provided below for additional information.

Please return the completed form via mail or fax to:
Catholic Charities Kinship Caregiver Program
Attn: Kinship Caregiver Worker – Danielle Kielar
2636 West State Street
Holiday Park Centre
Suite 301
Olean, New York 14760

FAX: (716) 372-3886
PHONE: (716) 372-0101