**UT BOLING CENTER FOR DEVELOPMENTAL DISABILITIES**
**SHELBY COUNTY RELATIVE CAREGIVER PROGRAM**
**INFORMATION AND REFERRAL FORM**

**PERSON TAKING REFERRAL: _____ DATE: _____**

**CAREGIVER'S NAME: _____ DOB: _____**

**ADDRESS: _____ ZIP CODE:_____**

**PHONE NUMBER: (HOME)_____ (WORK)_____ (CELL/PAGER)_____**

**CAREGIVER'S SSN:_____**

**HOUSEHOLD INCOME:_____**

| CHILDREN | DOB | RELATIONSHIP TO CAREGIVER | SEX | RACE | SSN | DISABILITIES |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

**IS CHILD IN LEGAL CUSTODY OF CAREGIVER? Yes _____ No_____**
**(Date of custody) _____**

**Was child previously in foster care? Yes _____ No_____ Dates_____**

**REFERRAL SOURCE:**

| NAME | AGENCY | ADDRESS | TELEPHONE# |
|---|---|---|---|
| | | | |

**REASON FOR REFERRAL: (Summarize family's need for services)**

**WAS FAMILY REFERRED FOR SERVICES OUTSIDE OF RELATIVE CAREGIVERS NETWORK?**

**YES _____ NO _____ REFERRED TO: _____**

**CASE MANAGER ASSIGNED: _____ DATE ASSIGNED: _____**

**TELEPHONE CONTACT DATE:_____ HV DATE:_____**

**SUPERVISOR'S SIGNATURE: _____ DATE: _____**

**FOR FURTHER INFORMATION, PLEASE CONTACT OUR OFFICE AT:**
**Phone: (901) 448-3133 or Fax: (901) 448-3534**
A program of the UT Boling Center for Developmental Disabilities and the Tennessee Department of Children's Services