

**Extended Family Support Program
Post Adoption Referral Form**

Client Information

CYCIS ID Number(s): _____

Caregiver Name: _____ Relation to Children _____

Child's Name: _____ Relation to Caregiver: _____

Child's Name: _____ Relation to Caregiver: _____

Child's Name: _____ Relation to Caregiver: _____

Child's Name: _____ Relation to Caregiver: _____

Primary Language: Caregiver: _____ Child: _____

Address and Apt #: _____ County: _____

City: _____ Zip Code: _____

Home Phone: _____ Work: _____

Adopted Parent's Name: _____ Phone: _____

Additional Information

	Yes	No
Child has been living with caregiver for more than 14 continuous days	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver wants to become guardian of the child.	<input type="checkbox"/>	<input type="checkbox"/>
Other needs besides cash assistance are present.	<input type="checkbox"/>	<input type="checkbox"/>
Adopted parent(s) died or incapacitated	<input type="checkbox"/>	<input type="checkbox"/>
Relative caregiver is seeking the adoption subsidy	<input type="checkbox"/>	<input type="checkbox"/>
There is a pending abuse or neglect investigation	<input type="checkbox"/>	<input type="checkbox"/>
Safety threat identified	<input type="checkbox"/>	<input type="checkbox"/>

Provide the stability of the child(ren)'s current living arrangement, the reason the child(ren) is living with the relative caregiver, and the length of time the child(ren) has been living with caregiver below.

Worker Information

Name: _____ Worker ID: _____

Agency: _____ Phone: _____

Address: _____ Fax: _____

City: _____ Zip Code: _____

Supervisor: _____ Phone: _____

Worker Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____