STAFF NAME & PHONE: Click or tap here to enter text.

REFERRING AGENCY: Click or tap here to enter text.

DATE: Click or tap to enter a date.

**** FAX COMPLETED FORM TO: 510.583.8060 ****

Lincoln Families
Kinship Support Services Program
Southern Alameda County
Initial Referral Assessment

Caregiver Name:				
City Where Caregiver Resides:				
Phone Number:				
Email:				
Child's Name & Relationship to Child:		Age:		☐ Check if child is American Indian or Alaska Native.
Child's Name & Relationship to Child:		Age:		☐ Check if child is American Indian or Alaska Native.
Child's Name & Relationship to Child:		Age:		☐ Check if child is American Indian or Alaska Native.

Needs assistance with (*select all that apply*):		**Notes:**
Guardianship or legal assistance	☐	
Support with medical concerns (coverage, care)	☐	
Finding food for the household	☐	
Finding housing resources	☐	
Finding resources for utilities bills	☐	
Finding furniture	☐	
Finding clothing	☐	
Finding employment	☐	
Finding transportation	☐	
Finding respite/childcare	☐	
Finding services for your child's special needs	☐	
Finding resources for alcohol / substance abuse challenges	☐	
Finding academic support	☐	
Finding counseling, mental health resources	☐	
Finding program(s) for your teen	☐	
Finding recreation activities	☐	
Financial Assistance (SSI, CalWorks, Foster Care, etc.)	☐	
Other:		