Tennessee Department of Children's Services

Relative Caregiver Program Family Information

Case Type: ☐ Case Management ☐ Direct Services TFACTS ID: _____ County: _____

Person Taking Referral: _____ First Contact Date: _____

Primary Caregiver's Name: _____ _____ _____ _____

First *Middle/Maiden* *Preferred* *Last*

Spouse Caregiver's Name: _____ _____ _____ _____

First *Middle/Maiden* *Preferred* *Last*

Address: _____ Zip Code: _____

Telephone Number: HM: _____ Work: _____ Email: _____

Employed: ☐ Yes ☐ No

Income Upon Eligibility: _____ Eligibility Date: _____ Income: _____

Income Eligibility Date: _____ Income: _____ Income Eligibility Date: _____ Income: _____

CHILDREN'S INFORMATION

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
NAME (First, Middle, Last, Preferred)						
Date of Birth						
Social Security Number						
Relationship to Caregiver						
Gender						
Race*						
Disability**						
Redetermination Date:						

*Information collected to aggregate demographic information and does not impact service eligibility.
**Information shared only to assist with case planning and does not impact service eligibility.

Redetermination Date:						
(continued)	**Child 1**	**Child 2**	**Child 3**	**Child 4**	**Child 5**	**Child 6**
Eligible for Services at Redetermination:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Eligible for Services:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Eligible for Services at Redetermination:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reason for relative placement						
Date of Placement						
Are all siblings together?						
Type of health insurance?						
Does child have Primary Care Physician?						
Does child have a dentist?						
Previous Placement						
School attending						
Educational Level						
Special Education						
Special Needs						

CAREGIVER INFORMATION

	Primary	**Secondary**
NAME (First, Middle, Last, Preferred)		
Social Security Number		
Date of Birth		
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Widowed	☐ Married ☐ Single ☐ Divorced ☐ Widowed
Race*		
Disability**		

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Gender		
Employed		
Level of Education		
Primary Care Physician		
Dentist		
Health Insurance		

COMMENTS/REDETERMINATION NOTES:

REFERRAL SOURCE

How did family hear about RCP	☐ Walk-In	☐ Agency (including church)	☐ RCP Outreach	☐ Friend	☐ Other
If Agency Referral, give: Agency Name					
Agency Address		Telephone Number			
Name of friend or other referral information					
Reason for referral					
Are there other services in the home?	☐ Yes	☐ No			
If yes, list services:					
Would family like to be on mailing list for support group?	☐ Yes	☐ No			

CM/FA Assigned _____ Date Assigned _____

First *Last*

Supervisor's Signature _____ Date _____

REASON FOR CLOSURE: _____

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CHILD(REN) BIRTH FAMILY INFORMATION

Birth Mother's Name _____ _____ _____ _____

First *Middle/Maiden* *Preferred* *Last*

Goal is Reunification: ☐ Yes ☐ No If no, why? ____

Address: _____ Zip Code: _____

Street *City*

Telephone Numbers: Home: _____ Work: _____ Other: _____

Birth Father's Name _____ _____ _____ _____

First *Middle/Maiden* *Preferred* *Last*

Goal is Reunification: ☐ Yes ☐ No If no, why? ____

Address: _____ Zip Code: _____

Street *City*

Telephone Numbers: Home: _____ Work: _____ Other: _____

Additional Comments:

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OTHER ADULTS IN HOUSEHOLD

	Adult 1	Adult 2	Adult 3	Adult 4
II. NAME (First, Middle, Last, Preferred)				
Social Security Number				
Date of Birth				
Race*				
Disability**				
Gender				
Employed				
Other Telephone Number				
Work Telephone Number				
Grade Level Completed				
Primary Care Physician				
Dentist				
Health Insurance				
Relationship to Caregiver				

COMMENTS/REDETERMINATION NOTES:

Note: Make copies of this form for multiple children who have multiple parents.

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