KEEP ME SAFE
Parenting Time and Exchange Centers
AGENCY REFERRAL FORM

Date: **Type:** **Location:**

Child Sexual Abuse Case: ◯ YES ◯ NO ◯ Undetermined

Selecting YES will open an additional form. Please complete both forms.

Referral Info

Name: _____ Referring Agency:_____

Phone:_____ Email:_____

Referral Reason: ◯ Out-of-home placement **Number of Visits per Week**: _____

◯ Family court/court ordered **Length of Visits**: _____ (hours)

◯ Other _____

Parent Contact Info

Visiting Parent 1		Relation to Child:	
Address:		Phone Number:	
Email:		Race:	
Gender:		Date of Birth:	
Visiting Parent 2		Relation to Child:	
Address:		Phone Number:	
Email:		Race:	
Gender:		Date of Birth:	
Other Visitor		Relation to Child:	
Address:		Phone Number:	
Email:		Race:	
Gender:		Date of Birth:	

Children's Information **"Resides With" means name and relationship to the child*

Child 1

Name:	DOB:	Gender:	Race:
Resides With:		Phone:	
Address:		Email:	
Transportation Provider:		Phone:	
Allergies or special considerations:			

Child 2

Name:	DOB:	Gender:	Race:
Resides With:		Phone:	
Address:		Email:	
Transportation Provider:		Phone:	
Allergies or special considerations:			

Child 3

Name:	DOB:	Gender:	Race:
Resides With:		Phone:	
Address:		Email:	
Transportation Provider:		Phone:	
Allergies or special considerations:			

Child 4

Name:	DOB:	Gender:	Race:
Resides With:		Phone:	
Address:		Email:	
Transportation Provider:		Phone:	
Allergies or special considerations:			

CLICK HERE to include additional children

Foster Parent(s): *(if applicable)*

Name: _____ Email: _____

Phone: _____

Is contact permitted between foster family and visiting parent(s)? ◯ YES ◯ NO

Guardian Ad Litem: *(if applicable)*

Name: _____ Email: _____

Phone: _____

Billing Information: *(if applicable)* Name:

Phone: _____ Address: _____

_____ Email: _____

All available Days and Times for visits:

Please provide a summary and background information related to this family or case. This information greatly assists KMS in providing a safe, nurturing environment and allows KMS to ensure staff is aware of any specific safety concerns or special needs unique to this family.

Submit your referral form by e-mailing it to kms@cadamn.org or mailing it to P.O. BOX 466, Mankato MN, 56002. If you have questions you can contact the Program Manager at kms@cadamn.org or by calling 507-625-8688 ext. 115.

The overall intake and scheduling process can take several weeks depending on number of referrals, availability and communication from all parties. KMS does their best to ensure the process moves as quickly as possible, but please prepare for a delay between submitting this form and getting visits started.