

**KEEP ME SAFE**  
 Parenting Time and Exchange Centers  
**AGENCY REFERRAL FORM**

**Date:** \_\_\_\_\_ **Type:** YES NO Undetermined **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:	Address:		Phone:
Allergies or special considerations:		Email:	Phone:

**Child 2**

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

**Child 3**

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

**Child 4**

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

**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](mailto: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](mailto: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.