

# KINSHIP CARE REGISTRY

Date \_\_\_\_\_

## PART I. CAREGIVER DEMOGRAPHIC DATA

1. \_\_\_\_\_  
Last Name, First Name M.I.

2.  Male  
 Female

4. \_\_\_\_\_ Phone \_\_\_\_\_  
Residential Address (Street, City, State, Zip Code)

5. \_\_\_\_\_  
County

6. Age: \_\_\_\_\_ (Date Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_) (DOB not required, but provides demographic data)  
Month Day Year

7. Household Number: \_\_\_\_\_ 7. Number of Children: \_\_\_\_\_  
(only enter # that are considered kinship care) 8. Ages: \_\_\_\_\_  
(kinship) \_\_\_\_\_

9. Relationship to Care Recipient  
1. Grandparent \_\_\_\_\_  
2. Aunt/Uncle \_\_\_\_\_  
3. Sibling \_\_\_\_\_  
4. Cousin \_\_\_\_\_  
5. Other relative: \_\_\_\_\_

10. Caregiver Interests: (Circle all areas applicable. If none, circle 99.)

- |                                |                              |                  |
|--------------------------------|------------------------------|------------------|
| 1. Support Groups              | 5. Legal Information         | 10. Other: _____ |
| 2. Childcare                   | 6. Head Start Information    | 11. Other: _____ |
| 3. Conferences                 | 7. Public/Private School     | 12. Other: _____ |
| 4. Educational Programs: _____ | 8. <b>Summer Scholarship</b> | 99. None         |
| _____                          | 9. Newsletter                |                  |
| _____                          |                              |                  |

11. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information Only  Yes  No (If no, then a referral is to be made)

REFERRAL MADE TO:  PGCSC Program  
 AAA Non-medical HCBS  
 Other Agency: \_\_\_\_\_  
List name of agency caller/client is referred to.

PGCSC Program Referral:  Behavioral Health  
 Kinship Care  
 Caregiver  
 Legal  
 SHIP/BE&A  
 Senior Dental Health

INTAKE BY: \_\_\_\_\_