***ALL QUESTIONS MUST BE ANSWERED OR THIS FORM WILL BE RETURNED AS INCOMPLETE***

Region Name:       County:

Case Name:

TWIST #:       Referral #:

Child(ren’s) names:       Name of relatives:

Relationship to child(ren):

Nature of abuse:  Physical  Neglect      (**type**)  Sexual

Check ***specific*** reasons children could not remain at home?

Serious Physical Abuse  Serious Substance Abuse  Sexual Abuse

Abandonment  Other, please give details:

Was FPP or other in-home services used to prevent removal:  Yes No

If no, list reason(s):

Have either of the birth parents lived with the relative since the child(ren) were placed there?

Yes  No

Placement date:

Date the KC-01 was completed and signed:

Date custody granted by Court:        Cabinet custody  Relative custody

Date home evaluation approved:

Date the assessment & substantiation on the custodial parent(s) was approved in TWIST:

If this date is more than 30 working days from the date of placement list the specific reason why:

List any monthly income of the child (children) including type and amount:

Start up costs recommended:  Yes  No

If yes, were community resources exhausted first?  Yes  No

If yes, list these:

Records checks completed on ALL household members:  Yes  No

If yes, did these individuals meet the guidelines per SOP: 4.5.4?  Yes  No

Has the relative been receiving KTAP since the placement occurred?

Yes  No

Internal Use only

Reviewer:       Date received from field:

Comments/Other:

Approved  Denied  Date: