Referral to CCNC Network/Custody Status Notification Form

This form is to be filled out by agency staff when a child comes into care of agency's foster home and/or when custody status changes. The applicable CCNC network will utilize this form to ensure the child is referred to the necessary services and the child's medical care team is kept up to date on status changes.

Referral Source Name & Agency: _____Date Sent: _____
Contact Number: _____
Contact Email: _____ Contact Fax: _____

DSS Social Worker Name & contact information: _____

Child's Name	DOB	Medicaid ID	DSS Custody Start Date	Medical Home/ Primary Care Provider	County of Placement

Reason for Notification

☐ New Placement ☐ Guardianship Placement ☐ Change in Placement ☐ Adoption
☐ Trial Placement; length of time: _____ ☐ Reunification with Biological Parent
(DSS retains custody in trial placement)

Child's Critical Health Information:

Known Medications (including dosage): _____
_____
_____

Known Allergies: _____
_____

Known Chronic Conditions: _____
_____
_____

Placement Information

The child currently resides at (address) _____
In the home of (name) _____
At the telephone number _____

Signature of Agency Staff Member: _____