



KINDRED CONNECT

APPLICATION FORM SUPERVISED CONTACT

PO Box 272 Dayboro QLD 4521

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Tel (07) 3425 1098

Fax (07) 3425 1098

Email contactus@kindredconnect.com.au

PARENT COMPLETING THIS FORM

Name:			
Contact Number:			
Email address:			
Are you happy for us to provide you information by email?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
What is your relationship to the child(ren):	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other <input type="checkbox"/>
Have you read the Service Fee Schedule?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Person/s to pay Service Fees	Father: <input type="checkbox"/>	Mother: <input type="checkbox"/>	Equally shared: <input type="checkbox"/>

YOUR EMERGENCY CONTACT PERSON

Name of emergency contact person			
Contact number			
Relationship (i.e., friend, sibling...)			
Is this person aware?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

OTHER PARENT'S DETAILS

Parent's name	
Address (if known)	
Parent's telephone contact details (if known)	
Parent's email contact details (if known)	
Name/contact of their legal representative (if known)	
Details:	

LEGAL DETAILS

Are there current Court Orders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details		

Please send completed forms to contactus@kindredconnect.com.au

Please attach copy of any relevant Court Orders i.e. DVO and Contact.

Do you have legal representation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Solicitor's Name & Legal Firm		
Contact number		
Company Address		
Solicitor's email address		
Do you consent to us contacting your solicitor?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has an Independent Children's Lawyer been appointed?	Yes <input type="checkbox"/>	No <input type="checkbox"/> Pending <input type="checkbox"/>
Do you consent to us contacting the ICL?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

ABOUT THE CHILDREN

Child's Name	Age	Date of Birth	Gender
			M <input type="checkbox"/> F <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>
Who does the child(ren) live with?			
Parent with Parental Responsibility for the child(ren)?			
Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Shared <input type="checkbox"/>	Other <input type="checkbox"/>
Additional information			

BACKGROUND DETAILS

Have you previously applied for/used another Children's Contact Service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If yes, please provide details e.g. Service name, dates accessed, issues</i>		
Do you give permission for us to contact the Service/s?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SERVICES REQUIRED

on-site (Contact Centre) <input type="checkbox"/>	off-site <input type="checkbox"/>
<i>Please provide details for off-site supervision *Please note offsite visits are at the Supervising Directors discretion*</i>	

Please send completed forms to contactus@kindredconnect.com.au

CONTACT SCHEDULE

Frequency

Twice weekly weekly fortnightly other

Duration

2 hours 3 hours 4 hours other

Days & times preferred

Preferred start date?

For how long to you expect to be involved with our Service?

3 months 6 months ongoing not sure

DEPT. CHILD SAFETY (CHILD PROTECTION)

Have there been any allegations of abuse or neglect reported to a child protection department (e.g. Child Safety, DoCs)? Yes No

If yes, what is the nature of the allegations?

Were these allegations investigated? Yes No

Has there been any involvement by Child Safety? Yes No

Are there any concerns relating to drugs or alcohol? Yes No

Has there been a history of family violence? Yes No

Has there been any Care and Protection Order (including Interim) court order relating to the children? If yes, please provide copy of order Yes No

HISTORY OF VIOLENCE / POLICE INVOLVEMENT

Do you have any concerns for personal safety? Yes No
If no, go to next section

Has there been a history of violence/abuse in parent's relationship? Yes No
If no, go to next section

If yes, please provide details of when did this occur? (DD/MM/YY)

While you were together Since separation Current / ongoing

Please indicate the type of violence

Physical Emotional Verbal Other

Were you or the other parent seriously hurt?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever been stalked/threatened by the other parent	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has a court ever made a restraining order (AVO/DVO/PPO) against you or the other parent?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<i>If no, go to next section</i>				
If yes, with respect to whom?				
If yes, when? (DD/MM/YY)				
Have the police ever been involved with you or the other party?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, please indicate which police service - <i>Please specify the location</i>				
Is there any information we should know about you or the other party for e.g. criminal charges? If yes, provide details;	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Any other circumstances/concerns we should be aware of?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<i>Please provide any additional comments, information and/or list any attached documentation</i>				

HEALTH & MEDICAL DETAILS

Does the child (ren) have any illnesses, allergy, disability, fears, special needs or medical requirements? (Please specify)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does either parent have any illness, allergy, disability, special needs, and medical requirements which may impact upon Contact? (Please specify)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are there any concerns relating to drugs or alcohol?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Details				

ETHNICITY

Language spoken at home?		Translator required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, is there a preferred translator?				

SUMMARY OF ISSUES

What are the reasons for seeking Supervised Contact Services?

INTAKE & ASSESSMENT

Do you have a preferred days and/or time to attend an Intake Interview?

Have you paid the Intake & Assessment Fee? Yes No

If yes, please attach receipt or quote reference number

If no, what is your preferred method of payment?

Credit Card Internet Transfer Cheque Payment Plan

Would you like us to provide details about payment plan options? Yes No

E.F.T Payment Details Account Name: **Kindred Connect**
Account Number: **13-321-1696**
BSB: **084-424 [NAB]**

Please note: Appointments for Intake Interviews are confirmed upon receipt of payment.

To the best of my knowledge, the information provided is full and accurate and no relevant information has been knowingly withheld.

Sign: _____ **if submitting referral by email, please check box**

Date: _____

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