



## Caregiver Permission to Contact Form

Kinship caregivers are grandparents, other relatives, and family friends who are full time caregivers of children. The New York State Kinship Navigator is a state-wide program that provides information and assistance to kinship families, and connects them with specialized services designed to support them.

**By signing this form, you are giving your permission for our staff to contact you about our services and offer information about your permanency options and other services available to you.**

**With your permission, we will call you!**

If you have questions about Kinship Navigator services, please call 877-454-6463 or email [navigator@nysnavigator.org](mailto:navigator@nysnavigator.org). Please go to the other side of this page, where you can complete the permission to contact form.

# PERMISSION FOR THE KINSHIP NAVIGATOR TO CONTACT YOU

Please sign and provide your contact information below, and then return to your staff person

Permission for Kinship Navigator to call you:  Yes  No (If No, Stop here)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Name of Primary Caregiver:** \_\_\_\_\_  
(Please PRINT legibly)

2. **Mailing Address:** \_\_\_\_\_ Apt Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. **Home Phone:** Area code: \_\_\_\_\_ phone: \_\_\_\_\_ - \_\_\_\_\_

4. **Cell Phone:** Area code: \_\_\_\_\_ phone: \_\_\_\_\_ - \_\_\_\_\_

5. **Other Phone:** Area code: \_\_\_\_\_ phone: \_\_\_\_\_ - \_\_\_\_\_

6. **Email Address:** \_\_\_\_\_

7. **What language do you prefer?**  English  Spanish  Other \_\_\_\_\_

8. **Preferences for contact (check all that apply)**

**Time of day:**  Morning (9-12)  Lunchtime (12-1)  Afternoon (1-4)  Evening (4-6)

**By**  Email  Mail  Home Phone  Cell Phone

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9. Would you agree for the referring worker to contact KN to inquire if contact was made?  Yes  No  
(If No, we will respect your privacy.)

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**Instructions for Staff:** Please complete the information below, and fax this form to 585-456-1676 or email a scanned copy to [navigator@nysnavigator.org](mailto:navigator@nysnavigator.org).

Unit: \_\_\_\_\_ County: \_\_\_\_\_

Staff Person: \_\_\_\_\_

Child Welfare Staff Only: Types of Placement:

"Temporary" (No Article Ten);  Article Ten "direct";  Article Ten into Article Six;  
 KinGAP;  Other \_\_\_\_\_

Does the client have a Safety Plan in place?  Yes  No

Brief Description of Caregiver Situation/Needs: \_\_\_\_\_

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Date fax/email sent \_\_\_/\_\_\_/\_\_\_

(Please fax the form even if caregiver declined to be contacted; this is important for our records).

**FAX NUMBER: 585-456-1676**