KALISPEL TRIBE OF INDIANS
Indian Child Welfare
934 S. Garfield Road
Airway Heights, WA. 99001
509-789-7630 Office
509-789-7675 Fax

CHILD ABUSE AND NEGLECT REFERRAL

CHILD(REN) IDENTIFIED AS VICTIM(S)		
Name of Victim:		
Date of birth:	Age:	Phone:
Current physical address:		
City:	State:	ZIP Code:
Enrolled Kalispel Tribe? Yes or No (Please circle) Member of Kalispel Tribal community? Yes or No	Enrolled in another Tribe? Yes or No (Please circle) List Tribe:	
Name of Victim:		
Date of birth:	Age:	Phone:
Current physical address:		
City:	State:	ZIP Code:
Enrolled Kalispel Tribe? Yes or No (Please circle) Member of Kalispel Tribal community? Yes or No	Enrolled in another Tribe? Yes or No (Please circle) List Tribe:	
Name of Victim:		
Date of birth:	Age:	Phone:
Current physical address:		
City:	State:	ZIP Code:
Enrolled Kalispel Tribe? Yes or No (Please circle) Member of Kalispel Tribal community? Yes or No	Enrolled in another Tribe? Yes or No (Please circle) List Tribe:	
PARENT IDENTIFICATION		
Mother Full Name:	Phone:	Tribal Affiliation:
Father Full Name:	Phone:	Tribal Affiliation:
Mother current physical address:		
Father current physical address:		
REFERENT INFORMATION		
Name:	Relationship:	
Phone:	E-mail:	
Current Physical Address:		
City:	State:	ZIP Code:
Request Call back? Yes or No	Requests Confidentiality? Yes or No	
SPECIFIC CONCERN (Describe specific person(s), behavior and condition, include time, where and when)		
WHEREABOUTS OF THE ALLEGED VICTIM(S) IF NOT AT HOME		
School Name & Address:		
Daycare Name & Address		
Other Name & Address:		

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ALLEGED PERPETRATOR IDENTIFICATION		
Name:	Relationship:	
Physical Address:		
City:	State:	ZIP Code:
Phone:	E-mail:	
Is the alleged perpetrator dangerous? Yes or No	Does the alleged perpetrator own or carry a weapon? Yes or No	

Is there anything else that the ICW Program should know about regarding the children, home or alleged perpetrator? For example, weapons in the home or gun owner? Violent or aggressive behavior? Drug home? Any additional information would be helpful. Thank you.

SIGNATURE OF REFERENT:	**DATE:**

OFFICE USE ONLY

TYPE OF CA/N:	☐ PHYSICAL ABUSE ☐ NEGLECT (i.e. medical, dental, emotional) ☐ SEXUAL ABUSE ☐ EMOTIONAL ABUSE ☐ SEXUAL EXPLOITATION ☐ OTHER: _____
REFERENT SOURCE OF INFORMATION	☐ FIRST HAND KNOWLEDGE ☐ CHILD DISCLOSURE ☐ JUDGEMENT BASED UPON CIRCUIMSTANTIAL EVIDENCE ☐ SECOND HAND INFORMATION
INTAKE DECISION	☐ INFORMATION ONLY ☐ ACCEPTED FOR INVESTIGATION. REFERRED TO: _____ ☐ THIRD PARTY REPORT. REFER TO: _____
RECEIVED BY:	**DATE:**

NOTE: Per KLOC, 7-20.04, The care of children is both a family and tribal responsibility. Any member of the Kalispel Tribe of Indians, persons residing within the jurisdiction of the Tribe, and tribal employees and contractors, who have reason to believe that a youth has been abused or neglected is required to file a report promptly.

Send completed form to the Indian Child Welfare Program.
Attention: ICW
934 S. Garfield Road
Airway Heights, WA. 99001
509-789-7630 office or 509-789-7675 fax
mvanderburg@camashealth.com
rallen@camashealth.com
sbrady@camashealth.com
sschryer@camashealth.com
wthomas@camashealth.com