

KEYTRAIN REFERRAL /TURNAROUND FORM

CLIENT NAME: _____ **ID#:** _____ **LAST 4 SS#:** _____
ADDRESS: _____
CONTACT #: _____ **REFERRAL DATE:** _____
DCF OFFICE _____ **DCF CASE MANAGER:** _____

_____ is being referred to the Workforce Center to register for
(Client Name)
Kansas Works and to complete at least one module of the KEYTRAIN assessment.
_____ must contact the Work Force Center
(Client Name)
at
(Location)
, no later than _____ to make an appointment to complete these requirements.
(Telephone#) (MM/DD/YY)

FOR WFC STAFF COMPLETION ONLY

Upon completion of the registration and assessment, please fill out the following information. Have the client return to the DCF office they applied to and send a copy of this form electronically to KWKr@dcf.ks.gov. Please include all requested information.

REGISTERED FOR KANSAS WORKS: YES **NO**

ASSESSMENT(S) COMPLETED:

KEYTRAIN DATE: _____ **WORKKEYS DATE:** _____
MODULE: _____ **CERTIFICATE LEVEL:** _____

RECOMMENDATIONS:

CLIENT FAILED TO MAKE CONTACT WITHIN _____ DAYS.

REPORTED BY: _____
CONTACT #: _____ **EMAIL:** _____
ADDR: _____