Special Kids Connect
Referral Form for Services, Education, and Programs

REFERRING ORGANIZATION INFORMATION	
Referring Date:	**Name of Person Making Referral:**

In what area is the family's primary need? SELECT ONE.

- ▢ Community & Government Services (including SSI/IHSS)
- ▢ Early Start Services (ages 0-3)
- ▢ Education/IEP Support
- ▢ Recreation & Social Programs
- ▢ Regional Center Services
- ▢ Other: _____

Referring Organization:

Referring Person's Phone: | **Referring Person's Fax:**

Referring Person's Email:

CHILD & PARENT/GUARDIAN INFORMATION	
Child's First & Last Name:	**Child's DOB:**
Diagnosis:	**Regional Center UCI #:**
Parent/Guardian's First & Last Name:	**Phone Number:**
Email:	**Preferred Language:**
Address (Street, City, State, Zip):	

Is the family currently receiving any services Special Kids Connect should be aware of? (mark all that apply)

- ▢ Early Start or San Andreas Regional Center
- ▢ Homeless Services
- ▢ Special Education (IEP / 504 Plan)
- ▢ Foster Care Youth Services
- ▢ Medi-Cal
- ▢ Other: _____

The family is aware of and has agreed to this referral: ▢ Yes ▢ No

REFERRAL NOTES / CLARIFICATION OF NEEDS - REQUIRED

Referrals will be followed up on within 10 business days.
If a family's needs are time-sensitive, please call our office at (831) 372-2730.

Please email referral to info@specialkidsconnect.org or fax to (888) 780-9982.