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

REFERRING ORGANIZATION INFORMATION		
Referring Date:	**Name of Person Making Referral:**	
Reason for Referral: ▢ 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 Org. Phone:	**Referring Org. Fax:**
	Referring Org. 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 / 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

Referrals will be followed up on within 5 business days.

Please email referral to info@specialkidsconnect.org or fax to (888) 780-9982.
For more information, call (831) 372-2730.