Special Kids Connect Family Resource Center Referral Form

Date of referral: _____

From: _____ Location: _____
Agency/Office Name (Address, City)

Contact: _____ Contact Phone Number: _____

Contact email address: _____

Title of person making referral: _____ Agency Fax #: _____

The family is aware of and has agreed to this referral. ☐ **Yes** ☐ **No**

This referral is being made for the following service: _____

_____

This child / family is currently receiving the following service(s):
( ) California Children Services (CCS) ▪ ( ) CASA of Monterey County / Child Advocate program
( ) Kinship Center ▪ ( ) Department of Social Services ▪ ( ) Door to Hope's "Parents as Teachers"
( ) Play Groups ▪ ( ) Go Kids ▪ ( ) MCSTART ▪ ( ) Shelter / Housing Asst. ▪ ( ) Food Assistance
( ) Early Start/San Andreas Regional Center ▪ ( ) Other_____

Child Name (First & Last):_____ DOB: _____

Diagnosis (Circle one: known or suspected): _____

Parent Name (First & Last): _____ PH:_____

Parent's Email: _____

Address:_____
City State ZIP

Home Language: ( ) English ( ) Spanish ( ) Other_____

Notes: _____

_____

REFERRALS SHOULD BE SENT TO:

Special Kids Connect ▪ 1900 Garden Road, Suite 230, Monterey, CA 93940
PH: (831) 372-2730 FAX 1(888) 780-9982 Email: info@specialkidsconnect.org