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)
( ) Kinship Center ( ) Department of Social Services ( ) Door to Hope's "Parents as Teachers"
( ) Play Groups ( ) Go Kids ( ) MCSTART ( ) Shelter
( ) Early Start/San Andreas Regional Center ( ) Other_____

Child Name:_____ Diagnosis _____ DOB: _____

Parent's Name: _____ Phone Number:_____

Parent's Email address: _____

Address:_____
City State ZIP

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

Referral Follow Up Date: _____

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: laura@specialkidsconnect.org