Elkhart and St. Joseph Counties Head Start Consortium

245 North Lombardy Drive, Suite A, South Bend, IN 46619

Family Services Referral Form

Parent: _____ **Date:** _____

Child: _____ **Site:** _____ **Session:** _____

Family Address: _____ **Phone Number(s):** _____

_____ _____

_____ _____

FACS: _____

This form identifies to Head Start's community partners/staff a possible need the family has that can be fulfilled by our partner agencies. Please review the information below and contact the family. A Family and Community Specialist has already discussed the need for further evaluation and/or services with the family. This form, completed by Head Start staff, is intended to inform the parent(s) of the referral and provides permission to refer the family and/or child for services.

Family Service / Issue Identified for Assistance for: **Entered in ChildPlus/PIR (Initial):**

Emergency Intervention: □ Food □ Clothing □ Shelter □ Other: _____

Housing Assistance: □ Subsidies □ Utilities □ Repairs □ Other: _____

Transportation Assistance: □ Subsidizing Public Transportation □ Other: _____
□ Family Services □ Child Services □ Other: _____

Educational Assistance: □ English as Second Language (ESL) □ Adult Education □ Denver II Activities
□ GED Preparation □ Financial Aid □ College Enrollment

Employment Assistance: □ Job Training □ Placement Services □ Other: _____

Substance Abuse: □ Prevention Services □ Treatment Services □ Tobacco Cessation □ Other: _____

Child Abuse & Neglect: □ Prevention Services □ Treatment Services □ Other: _____

Family based services: □ Domestic Violence Services □ Child Support Assistance
□ Health Education □ Assistance to families of incarcerated individuals
□ Parenting Education □ Marriage Education □ STEP □ Triple P
□ Other: _____

Immunization, Medical, Dental Information: Follow up _____ Referrals _____ Other_____

Health Insurance: _____

For Mental Health Manager purposes only:
□ Family Services □ Behavior
□ Child Services □ Social/Emotional
□ Other: _____

Other Assistance for child needed in following areas:
□ Special Education Observation Request □ Hearing
□ Vision □ DENVER II □ Physical Development
□ Other: _____

The parent signature on this form is acknowledgement of receipt and authorization to provide additional services. If there are questions or concerns, please contact the Family and Community Specialist at Head Start.

Parent Signature: _____ **Date:** _____**HS Staff Signature:** _____