



**Family Advocate Referral Form**  
4507 Del Rio Avenue #1, Atascadero, CA 93422  
1802 Chestnut Street, Paso Robles, CA 93446  
Phone (805) 794-0217 | FAX (805) 462-8901  
Fax or email Family Advocate Services Director,  
Carrie Collins [Carrie@linkslo.org](mailto:Carrie@linkslo.org)

**\*\*Must be Filled out as Completely as possible\*\***

Child Referred: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Referral \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Caretaker: \_\_\_\_\_ Parent Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_ Best time to reach family: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Language:  English  Spanish  Other \_\_\_\_\_ Family notified of referral:  Yes  No

Medical Insurance:  MediCal/CenCal  Private \_\_\_\_\_  None/Other \_\_\_\_\_

Sibling:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Site: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Site: \_\_\_\_\_

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Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Site: \_\_\_\_\_

Person making the Referral: \_\_\_\_\_ School/Agency: \_\_\_\_\_

Phone & Email of Person Making the Referral: \_\_\_\_\_

**What services is the family requesting?**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Birth - 5 Services | <input type="checkbox"/> Emotional/Behavioral         | <input type="checkbox"/> School Supplies   | <input type="checkbox"/> Health/Dental |
| <input type="checkbox"/> Academic/SARB      | <input type="checkbox"/> Basic Needs (food, clothing) | <input type="checkbox"/> Housing Resources | <input type="checkbox"/> Financial     |
| <input type="checkbox"/> Counseling         | <input type="checkbox"/> DSS/CWS                      | <input type="checkbox"/> Transportation    | <input type="checkbox"/> Childcare     |

Please provide any additional information regarding services the family is requesting:

**Interventions That Have Been Tried:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bilingual Education           | <input type="checkbox"/> Title 1           | <input type="checkbox"/> Referrals to Other Agencies |
| <input type="checkbox"/> Alternative School            | <input type="checkbox"/> SST/FST/THT       | <input type="checkbox"/> Learning Center             |
| <input type="checkbox"/> School Counseling             | <input type="checkbox"/> Special Education | <input type="checkbox"/> S.A.F.E. Intensive Meeting  |
| <input type="checkbox"/> School Based Advocacy Support | <input type="checkbox"/> Others: _____     |  |

Confirmed with referring party? Date: \_\_\_\_\_

Information entered into Apricot? Date: \_\_\_\_\_