Family Advocate Referral Form S.A.F.E SYSTEM OF CARE
4507 Del Rio Avenue #1, Atascadero, CA 93422
665 26th 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

****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:_____
Child's Name: _____ DOB: _____School Site:_____
Child's Name: _____ DOB: _____School Site:_____
Child's Name: _____ DOB: _____School Site:_____
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?

☐ Birth - 5 Services	☐ Emotional/Behavioral	☐ School Supplies	☐ Health/Dental
☐ Academic	☐ Basic Needs (food, clothing)	☐ Housing Resources	☐ Financial
☐ Counseling	☐ DSS/CWS	☐ Transportation	☐ Childcare

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

_____

_____

_____

Interventions That Have Been Tried:

☐Bilingual Education	☐Title 1	☐Referrals to Other Agencies
☐Alternative School	☐SST/FST/THT	☐Learning Center
☐School Counseling	☐Special Education	☐S.A.F.E. Intensive Meeting
☐School Based Advocacy Support	☐SARB	☐Others: _____

Confirmed with referring party? Date:

Information entered into Apricot? Date: