



Engage. Empower. Inspire.

LAKES REGION COMMUNITY SERVICES
STEP AHEAD PROGRAM REFERRAL FORM

Referral Date: \_\_\_\_\_

Primary Parent/Caregiver's Name: \_\_\_\_\_

Other Parent/Caregiver in Home: \_\_\_\_\_

Children in Household Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

Description of Concerns/Needs: \_\_\_\_\_

Primary Reason for Referral: (Select one):

- Prevention (primary prevention) services
Early Intervention (secondary prevention) services
Crisis (tertiary) services

Does a family member already receive services through LRCS? YES / NO

Name of family member receiving LRCS support?: \_\_\_\_\_

Name of support program: \_\_\_\_\_

Is there current DCYF involvement? (select one) YES / NO

If Yes, which child(ren)? \_\_\_\_\_

If Yes, is it an open assessment or open case? (select one) OPEN ASSESSMENT / OPEN CASE / UNKNOWN

Referral Source (Specify name of agency if applicable): \_\_\_\_\_

Name of referral source: \_\_\_\_\_ Email: \_\_\_\_\_

Is the family aware of referral? YES / NO

How did you learn about the Step Ahead Program? (Specify all sources): \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_