



Department of Child and Family  
**REFERRAL FORM**  
Education Consultation, Advocacy & Mediation Services

FIRST  
NAME: \_\_\_\_\_ LAST \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME TELE # \_\_\_\_\_ CELL # \_\_\_\_\_

WORK # \_\_\_\_\_ PARENT/GUARDIAN \_\_\_\_\_

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DSS WORKER: \_\_\_\_\_

TELE # \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ LEA: \_\_\_\_\_

GRADE: \_\_\_\_\_ IEP/504 \_\_\_\_\_

OTHER COLLATERALS: \_\_\_\_\_

GOAL OF SERVICE: \_\_\_\_\_

\*Approved units allowed: Monthly \_\_\_\_\_ Weekly \_\_\_\_\_ Total \_\_\_\_\_

\*Name/address of who to send invoice to: \_\_\_\_\_

\*Supervisor or Key Program Supervisor's Signature: \_\_\_\_\_

**CCS Internal use only**

Assigned to \_\_\_\_\_

Date Assigned \_\_\_\_\_ Initial of person assigning \_\_\_\_\_  
(return to DSS when you are assigned case)

\* If these are not filled in case will not be assigned.