Submit by E-mail | Print Form

Lorain County Children and Families Council
Family Services Referral Form FAX to LCCFC at (440) 284-4628

Parent/Caregiver Name: _____
Last First Relationship to Child

_____
Last First Relationship to Child

Child: _____ ___/___/___
Last First Date of Birth

Child: _____ ___/___/___
Last First Date of Birth

Child: _____ ___/___/___
Last First Date of Birth

Address: _____
Street Address City Zip

***Phone Number**: ( ) _____---_____ **Cell:** ( ) _____ --- _____*

Referring Agency: _____

Referring Contact Person: _____
Name Title

(_____)_____-_____ _____
Phone Number Email

CHILD MUST BE AGE 0 – 21 TO RECEIVE SERVICES: Check all that apply

☐ Referred Child is Medically Fragile ☐ Child has current or previous involvement with Children Services

☐ Referring Child has Current or Previous Involvement in Court
County: _____ *Reason:* _____ *Year:* _____

☐ Child has suspected or diagnosed developmental delay or disability or current I.E.P.

☐ Child has suspected or diagnosed alcohol or drug concerns

☐ Child has suspected or diagnosed behavioral or mental health concerns

☐ Child has Educational Concerns ☐ Truancy ☐ SPED ☐On IEP ☐Expulsion School System:_____

Family Characteristics Indicated by Referring Person or Family: *Check all that apply.*

☐ History of Alcohol or Drug Abuse *Current Recent Past* - ☐ Other family members ☐Parent/Caregiver

☐ Mental Health Issues - ☐ Other Family Members ☐ Parent/Caregiver

☐ Family/Child(ren) Involved in Counseling ☐ Physical/Sexual/Emotional Abuse Issues ☐ Parent Incarceration

☐ Domestic Violence Issues ☐ Foster/Relative Care ☐ Homelessness: *Current Pending Past*

☐ Employment/Mobility Concern Explain: _____

☐ Family in crisis or is instable Explain:_____

For LCCFC Staff Only: Family must be contacted within 3 business days of receipt of referral

Fax received on: ___/___/___ Family contacted on: ____/___ /___ Referral contacted on: ___/___/___

Assessment conducted on: / / Initial Family Team Meeting held on: / / Staff Initial: