Interagency Referral Form

Date Sent:_____ Referring Agency:_____ Date Received:_____

Referring Staff Name:_____ Phone:_____

Child's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Date of Birth:_____

Residence Address:_____ City:_____State:_____

Zip Code:_____ County:_____ School District:_____

Phone:_____ Email:_____ Family's Primary Language:_____

Interpreter Needed?: ☐ Yes ☐ No Secondary Phone Contact/Case Manager:_____

Program of Interest: *(You may check more than one box.)*

EOCF:

☐EHS/HS Home-Based (Prenatal-5)
☐HS/ECEAP Part-Day/School Day/Full-day (3-5)
☐Full-Day Subsidized EHS/HS (0-5)

Innovative Services:

☐ECEAP (3-5)
☐Child Care

ESD 112:

☐EHS Home-Based (Prenatal-3)
☐EHS Center-Based (0-3)
☐ECEAP (3-5) ☐Early ECEAP (0-3)
☐ESIT (Early Intervention, 0-3)
☐Child Care (6-12 years)
☐1-2-3 Grow & Learn (Playgroups)

Describe Reason for Referral: *(Examples include: Family choice, out of service area, no capacity, etc.)*

I acknowledge that this is not an application for enrollment, but a statement that I am interested in receiving a phone call from (name of agency)_____ to learn more about program services.

I agree that the status of this referral will be shared among the agencies.

Parent/Guardian signature: _____ (or) Consent given by phone ☐ Date:_____

Verbal consent received by: (print staff name): _____ Date:_____

Innovative:
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TO BE COMPLETED BY RECEIVING AGENCY

Status of Referral: ☐Placed on wait list ☐Enrolled ☐Not eligible for services ☐Declined services
☐Referred to another program ☐Could not reach family

REV. 5.8.23