

Manitowoc County Human Services Department

CHILDREN WITH SPECIAL NEEDS REFERRAL FORM

Date of Referral:

Information of Person Making Referral:

Name:

Address:

City/State:

Telephone:

Email:

Child's Information:

Name:

DOB:

Address:

Age:

City/State:

Sex: M F

Telephone:

Social Security:

Medical Assistance Number:

Private Insurance:

Mother's Information:

Name:

DOB:

Address:

Phone:

Email:

Father's Information:

Name:

DOB:

Address:

Phone:

Email:

Other Children in Home:

Name:

DOB:

Name:

DOB:

Name:

DOB:

Name:

DOB:

Type of Disability:

Developmental Physical Autism Medical Mental Health

Diagnosis:

Who Diagnosed/When?

Reason for Call/Referral:

Current Services:

- **School:**
- **Doctor:**
- **Therapist:**
- **Other:**

Juvenile Justice Involvement

Child Protective Services Involvement

FOR OFFICE USE ONLY

ASSIGNED SERVICE COORDINATOR:

Date:

ACTION:

OUTCOME:

WAITING LIST:

- CCOP (Children’s Community Options Program)
- Wraparound/Mentor
- CCS
- CLTS
- SSI
- Katie Beckett