Eliot Family Resource Centers

548 Broadway, Everett - Maple Ave. Entrance
FRC@Eliotchs.org - 781.581.4750

Referring Agency _____ Phone number_____

Person Making Referral _____ Title_____ Contact_____

Parent's Name_____ DOB_____

Address_____

Phone number_____ Email _____

Prefered Language _____ Country of Origen_____

Child's Name _____ DOB_____

School _____Grade _____ IEP Yes No

DCF Involvement Yes No Explain _____

Other siblings in the home Yes No - if yes, ages: _____

Please details of concerns:

_____

_____

_____

_____

Are you currently receiving services from other agencies, please list them:

Name: _____ Contact Info _____

Name _____ Contact info _____

What other information could be beneficial for family to receive:

- CRA Support
- Evidence Based Parenting class
- Parent Support Groups
- School related support
- Mental health support and referrals
- Financial Support (Fuel assistance, Rent, Food Insecurity, Diapers)
- Education (ESL, Highset, Computer trainings, other)
- Housing information and applications
- Teen Support Groups
- Health Law Advocates

I authorize a referral to be made to the Family Resource Center for the purpose of a follow up on myself and/ or my child. I do understand that the Family Resource Center may reply back to the referring agency by phone/ email or paper on the services I received.

Yo autorizo a la agencia listada en este documento para que haga un referido al Family Resource Center con el propósito de brindarle un servicio a mi o a mi hijo. Entiendo que el Family Resource Center podra responder a la agencia que esta haciendo el referido por medio de una llamada, emil o por escrito para compartir información acerca del servicio prestado.

_____ _____ _____

Clients Name - Nombre del Cliente Signature - Firma Date - Fecha

*for verbal consent please especified *