Wayne County
Request for Service Coordination

Date: ________________

Child's Name: ________________________ DOB: ____________
Address:______________________________ Sex: □ F : □ M
City: ________________________________ School District: _________________
Telephone: ___________________________ School Grade Level: ______________
School Placement: □Regular □ CD □LD □MH □MR/DD

Other Children Names & DOB: ____
____

Mother's Name: _____________________ Legal Custodian: ____ Yes ____ No
Address:__________________________ Employer: _______________________
City: ____________________________ Telephone:_______________________

Father's Name: _____________________ Legal Custodian: ____ Yes ____ No
Address:__________________________ Employer: _______________________
City: ____________________________ Telephone:_______________________

Organizations Currently Involved with the family (include a √ for all family members)

□ Anazao Community Partners
□ Children Services
□ Job and Family Services
□ Juvenile Court
□ Health Care Provider ________
□ One-Eighty
□ Catholic Charities
□ Brd of DD (Ida Sue)
□ Primary Care Physician__________
□ The Counseling Center
□ Medicaid Provider _____________
Other______________________

- Referral Source:____

Reason for Referral:
____
____
____

Name of Person Completing Form:________________________________
Telephone Number: _______________________Email Address:______________________

Signature of Parent/Guardian (s) or Entity with Legal Custody of Child(ren)

Print Name ______________________ Signature______________________
Print Name______________________ Signature______________________
Date Received ____________________