LRCS FAMILY RESOURCE CENTER
Engage. Empower. Inspire.

LAKES REGION COMMUNITY SERVICES
STEP AHEAD PROGRAM REFERRAL FORM

Referral Date: _____

Primary Parent/Caregiver's Name: _____

Other Parent/Caregiver in Home: _____

Children in Household Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Address: _____

Phone:_____ Cell Phone: _____ Email: _____

Mailing Address (if different from above): _____

Description of Concerns/Needs: _____

_____

_____

Primary Reason for Referral: (*Select one*):

- ☐ Prevention (primary prevention) services
- ☐ Early Intervention (secondary prevention) services
- ☐ Crisis (tertiary) services

Does a family member already receive services through LRCS? YES / NO

Name of family member receiving LRCS support?: _____

Name of support program: _____

Is there current DCYF involvement? (*select one*) YES / NO

If Yes, which child(ren)? _____

If Yes, is it an open assessment or open case? (*select one*) OPEN ASSESSMENT / OPEN CASE / UNKNOWN

Referral Source (*Specify name of agency if applicable*): _____

Name of referral source: _____ Email: _____

Is the family aware of referral? YES / NO

How did you learn about the Step Ahead Program? (*Specify all sources*): _____

Name of person completing form: _____

Signature: _____ Date: _____

Family Resource Center • 719 N. Main St, Laconia, NH 03246
603.524.8811 • FAX: 603-524-0702 • www.lrcs.org

LIVE UNITED United Way Granite United Way

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Office use only:
REF #: _____

Family Support Specialist: _____