# Lakeshore CAP Connections Count Program

# Referral Form

*Agency Representative*

Referral Date:________________________ Referring Agency: _______________________________________

Referral Contact Name: _______________________________Contact Phone #: _________________________

*Fill Out for Your Household*

***What services would your family like more information about? (Check all that apply)***

- ☐ Income/Benefits Eligibility
- ☐ Health Care Access/Primary Care Doctor
- ☐ Dental Care
- ☐ Housing/Homelessness
- ☐ Employment/Job Training
- ☐ Home Safety
- ☐ Child Health/Behavior/Development
- ☐ Domestic Violence/Safety
- ☐ Mental Health
- ☐ Transportation
- ☐ Nutrition/Food Access
- ☐ Utilities (gas, electric, phone, heat)
- ☐ Parenting
- ☐ Alcohol or Drug Recovery
- ☐ Prenatal Care
- ☐ Social Support/Community Connections
- ☐ Child Care
- ☐ Access to Community Resources *(specify)*: ____________________________________________________
- ☐ Other *(specify)*:___________________________________________________________________________

*Please Print*

**Adult Name(s):** ________________________________________________________________________

**Address:** ______________________________________________________________________________

**City, State, Zip:** ________________________________________________________________________

**Telephone Number:** ______________________________________________________________________

**Email:** ________________________________________________________________________________

**What's the best way and time to contact you?** _________________________________________________

*(Phone, text, email? AM or PM?)*

**Is there at least one child under age 5 living in your home? ____Yes ____No Are you pregnant? ____Yes ____No**

**# of Adults living in the home ___________ # of Children living in the home __________**

**Ages of Children:** ________________________________________________________________________

**I give permission to Lakeshore CAP, Inc. to use this information for a period of twelve (12) months as part of this referral process and to document this information in a secure database.**

***Participant Signature:*** ____________________________________________***Date:*** ___________________________

For more information regarding the Connections Count Program, please contact Lakeshore CAP, Inc at 920-682-3737
702 State Street, PO Box 2315, Manitowoc, WI 54221-2315

FAX Referral Form to 920-686-8700

Rev. 4/2018