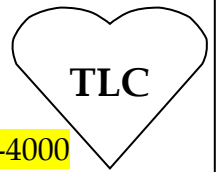


**CONFIDENTIAL**



**TLC REQUEST FOR SUPPORT SERVICES**  
**FAX: (562) 469-7155 Phone: (562) 904-3577**



Please consult with the Department of Children and Family Services at (800) 540-4000 in cases of suspected child abuse, neglect and domestic violence.

Immediate Action Required

**\*ALL INFORMATION ON THIS FORM IS REQUIRED, PLEASE DO NOT OMIT.**

- 1. Parent/Guardian notified that TLC will be contacting them?  Yes Date: \_\_\_\_\_
- 2. Parent/Guardian is Spanish speaking only?  Yes  No
- 3. Active IEP?  Yes  No

**Indicate area of need or concern:**

- Counseling
- Dental
- Food
- Health Insurance
- Health Clinic
- Parenting Ed.
- Vision

Date \_\_\_\_\_ School \_\_\_\_\_ I.D. # \_\_\_\_\_ Teacher/Counselor \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Grade \_\_\_\_\_ D.O.B. \_\_\_\_\_

Parent(s)/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Contact Phone #1 \_\_\_\_\_ Contact Phone #2 \_\_\_\_\_

Referred by: \_\_\_\_\_ ext. \_\_\_\_\_ Title: \_\_\_\_\_  
(Please Print)

**BRIEFLY** describe student's/family's need or problem \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. **If** mental health concerns are described above, **date** school psychologist was contacted \_\_\_\_\_

2. **If** child abuse, neglect or domestic violence described, date DCFS contacted \_\_\_\_\_

Were you given a 19 digit referral #?  Yes  No

3. **If** you mentioned above suicide ideation, a risk assessment must be completed by school site:

Date of risk assessment \_\_\_\_\_ by: \_\_\_\_\_ ext. \_\_\_\_\_

Principal/Assistant Principal: \_\_\_\_\_  
(PRINT) (SIGNATURE)

**TLC Use Only**

DATE RECEIVED: \_\_\_\_\_

INTAKE STAFF: \_\_\_\_\_

- ELL
- Foster
- Homeless
- Special Education