# Black Child Legacy Campaign
# Referral Form

<table>
<tr><td colspan="6">Referral Source Information</td></tr>
<tr><td colspan="6">Select Site | CIL for referral: Choose an item.</td></tr>
<tr><td colspan="6">Date Referred:</td></tr>
<tr><td colspan="3">Your Name & Position:</td><td colspan="3">Agency:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Office#:</td><td colspan="2">Fax #:</td></tr>
<tr><td colspan="2">City and Zip Code:</td><td colspan="4">Email:</td></tr>
<tr><td colspan="6">Family | Contact Information</td></tr>
<tr><td colspan="3">Parent/Guardian:</td><td colspan="3">Date of Birth</td></tr>
<tr><td colspan="3">Address:</td><td>Apt. #</td><td colspan="2">☐ Male ☐ Female ☐ No Response</td></tr>
<tr><td>City:</td><td colspan="2">Zip Code:</td><td colspan="3">Email:</td></tr>
<tr><td>Phone#1:</td><td colspan="3">Phone #2:</td><td colspan="2">Phone#3:</td></tr>
<tr><td colspan="6">Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Pacific Islander</td></tr>
<tr><td>Fluent in English? ☐Yes ☐ No</td><td colspan="5">If no, specify language:</td></tr>
<tr><td colspan="6">Household Demographics</td></tr>
<tr><td>Child A:</td><td>Birthdate:</td><td colspan="4">School/District</td></tr>
<tr><td>Child B:</td><td>Birthdate:</td><td colspan="4">School</td></tr>
<tr><td>Child C:</td><td>Birthdate:</td><td colspan="4">School</td></tr>
<tr><td>Child D:</td><td>Birthdate:</td><td colspan="4">School</td></tr>
<tr><td colspan="6">Additional Family Information:</td></tr>
<tr><td colspan="6">Identified Needs</td></tr>
<tr><td colspan="2">☐ Adult education<br>☐ Advocacy<br>☐ Child care<br>☐ Child education<br>☐ Counseling<br>☐ Domestic violence<br>☐ Employment</td><td colspan="2">☐ Family recreation activities<br>☐ Financial/Other Public Assistance<br>☐ Food/Nutrition<br>☐ Health insurance/Medical access<br>☐ Housing/Shelter<br>☐ Isolated/No Support<br>☐ Language barriers</td><td colspan="2">☐ ☐ Legal assistance<br>☐ Mental/Physical disability<br>☐ Parenting skills<br>☐ Pregnancy/Prenatal care<br>☐ Substance abuse (AOD)<br>☐ Teen resources/services<br>☐ Transportation</td></tr>
<tr><td colspan="6">☐ Other:</td></tr>
</table>

**Please email referral form to [RAACD@shfcenter.org](mailto:RAACD@shfcenter.org) or a Community Incubator Lead near You**

Received by BCL Team: ________________________________ Date: ________________