Family Center Referral Form

Family Center for Children and Youth
with Special Health Care Needs
320 S Walnut Street 6TH Floor
Lansing, MI 48913

Fax 517-241-8970

Family Phone Line 1-800-359-3722
www.michigan.gov/cshcs
cshcsfc@michigan.gov

Family Support

- ☐ Parent-to-Parent Support Network
- ☐ Information on Conference Scholarships
- ☐ Sibling Support / Workshops
- ☐ Support for Family/Youth Transition
- ☐ Bereavement Notification – Child's Date of Death _____
  - ☐ Family request for Bereavement Support and Resources
- ☐ Connect to Community-Based Organizations
- ☐ Connect to State or National Organizations
- ☐ Quarterly Newsletter
- ☐ Other _____

Information to be Released (please print)

_____ _____
Parent/Caregiver/Legal Guardian's Name Phone Number

_____ _____
Child's Name Child's Primary Diagnosis

_____ _____
Email Address CSHCS ID# or Medicaid ID#

_____ _____ _____
County of Residence Race (optional) Primary Language (optional)

_____ _____
Parent/Caregiver/Legal Guardian's Signature Date

☐ Check here if parent gave you verbal permission to release their information.

CSHCS LHD Information (please print)

_____ _____
CSHCS LHD: Phone Number

_____ _____
Printed Name of Referring Individual Date

Please fax this completed form to the Family Center at 517-241-8970