



PACC Referral Form

Please include any additional forms or information, such as a Release of Information if needed, when emailing back this form. Please email safefamilies@lssmn.org or call 612-454-0262 with any questions.

CLIENT'S INFORMATION:

LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE
PHONE	BEST TIME TO CONTACT
EMAIL	PRIMARY LANGUAGE SPOKEN IN THE HOME

AGENCY RECEIVING INFORMATION

Provider/Agency Name: Lutheran Social Services – Ellen Brown

Address: _____

Phone Number: (612) 454-0262

Fax Number: _____

CLIENT PARTICIPATION REQUIREMENT

___ Client is required to complete ___ amount of hours or months of intensive, individualized parenting education.

___ Client is required to complete ___ amount of hours or months of intensive, individualized parenting education

___ Other referrals or resources needed: _____

Additional notes that may be helpful to Agency **receiving** the referral:
