Rowell Family Empowerment of Northern California, Inc.

Office: 530-226-5129 **Fax**: 530-226-5141

Referral Type: ☐ Early Intervention ☐ Respite ☐ General/Other: _____

Agency Name: _____

Service Provider Name: _____

Phone Number: _____

E-mail Address: _____

- We are an Early Start Family Resource Center, serving families of infants and toddlers, birth to 3 years of age, who have a diagnosed or suspected disability.
- We are also a Family Empowerment Center that serves families with children ages 3 to 22.
- We offer parent-to-parent support and help parents, families and children locate and use needed services.
- Our respite program offers personalized support, love and attention to children, youth and adults with a diagnosis.

Please Print or Type – ALL information is required for our funding

Child's Information	
Child's Name:	Child's DOB:
Disability or Suspected Disability:	
Child's Ethnicity:	☐ Male ☐ Female ☐ Conserved Adult
Parent/Guardian's Information	
#1-Parent/Guardian Name (main contact):	Cell # ( ) -
Home Number: ( ) -	E-mail address:
Address:	City, Zip Code:
County of Residence:	Preferred form of Contact: ☐ Email ☐ Text ☐ Phone
Parent/Guardian's Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other (specify)	
Ethnicity: ☐ White ☐ Hispanic/Latino ☐ Af Am ☐ Am Ind ☐ Decline to State ☐ Other	
Relationship to Child: ☐ Biological ☐ Foster ☐ Kinship ☐ Other (specify)	
#2-Parent/Guardian Name:	Cell # ( ) -
Home Number: ( ) -	E-mail address:
Address:	City, Zip Code:
County of Residence:	Preferred form of Contact: ☐ Email ☐ Text ☐ Phone
Parent/Guardian's Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other (specify)	
Ethnicity: ☐ White ☐ Hispanic/Latino ☐ Af Am ☐ Am Ind ☐ Decline to State ☐ Other	
Relationship to Child: ☐ Biological ☐ Foster ☐ Kinship ☐ Other (specify)	
Parent/Guardian's Signature:	
Date	