State of Illinois Department of Children and Family Services

NIU Educational Access Project for DCFS Referral Form for Education Assistance

Referral Source Informati	on	
Name:		Date:
Email:		Phone:
Agency/Region or School/Dist	trict:	
Student Information		
Name:		DCFS ID:
D.O.B.:	Gender:	Ethnicity:
Race:		Primary Language:
Placement:		
Caregiver:		Phone:
Address:		
Caseworker:		Phone:
Caseworker Agency:		Phone:
Student School Information	on	
School Name:		Grade:
School Contact:		
Email:		Phone:
Education Program		If Other, Specify:
Please explain the primary educational problem:		
For Office Use Only		
Date Received:		Date Acknowledged:
Staff/Comments:		