

**Request for Services**

# \*\*\*FAX to 1-863-583-0671 or EMAIL to Upliftlakeland@gmail.com\*\*\*

**First Name: Last Name: Middle Initial:**

**Preferred Name: Date of Birth: / / Age:**

# Gender: Ethnicity: Preferred Language:

**Street Address: Apt #:**

**City: State: Zip Code:**

**Legal Guardian: Telephone #: ( ) -**

Describe reason for service request:

Please specify area(s) of concern:

|  |  |  |
| --- | --- | --- |
| **Conflict Resolution Depression** | **Family Interaction Sexual Abuse** | **Juvenile Delinquency Truancy** |
| **Anger Management** | **Physical Abuse** | **Substance Use/Abuse** |
| **Social Skills** | **Medical Problems** | **Legal Issues** |
| **Peer Relations** | **Medication Noncompliance** | **Other:** |

Please specify area(s) of need:

|  |  |  |
| --- | --- | --- |
| **Housing Entitlements** | **Education Employment** | **Daily Living Activities Primary Support System** |
| **Service Coordination** | **Financial** | **Legal** |

Has the individual been hospitalized within the last 12 months? Yes No Are requested services mandated by court order? Yes No

Referring Entity/Agency: Telephone: ( ) - Fax: ( ) -

Person Making Referral/Title:

**Signature: Date: / /**