



Application for Professional Referral Treatment Financial Assistance

Student's Name _____ Date _____

Age _____ Grade _____ School Building _____

Referral made by _____
School or Organization _____
Phone # _____
Email _____

PARENT INFORMATION

Name Parent 1 _____

Phone _____

Address _____

City _____

Name Parent 2 _____

Phone _____

Address _____

City _____

* Do parents know that you are requesting assistance? Yes No

Please complete the following to the best of your ability; check all that apply:

Student is a resident of Livonia and attends Livonia Public Schools

Student has completed grade 2

Family meets income eligibility guidelines and receives free lunch

Family meets income eligibility guidelines and receives reduced lunch

Student performs below grade level expectations in 2 or more disciplines

Student currently receives academic intervention services

If so, list disciplines: _____

Student reads below grade level: DRA or other _____

Based on knowledge of the family support system, it is reasonable to expect:

Student will have transportation to/from a Livonia office 1X per week

An adult will do 20-minute home activities with student 5X per week