



APPLICATION FORM FOR FEE FOR SERVICE

Referral Source Information	Name (who is completing this form):	
	Phone #:	Email:
	Address:	
	Your relationship with child(ren): (Please check all that applies) <input type="checkbox"/> Custodial Parent; <input type="checkbox"/> Access Parent; <input type="checkbox"/> Mother; <input type="checkbox"/> Father; <input type="checkbox"/> Other:	
	Attorney involved: <input type="checkbox"/> Yes (please fill his/her contact info on the next line); <input type="checkbox"/> No	
	Attorney's name and contact number:	
	MCFD or VACFSS involved with the family? <input type="checkbox"/> Yes; <input type="checkbox"/> No	

Child(ren) Information	If there are more than 3 children involved, please fill another page of application.	
	Name of Child:	
	Age:	Gender:
	Name of Child:	
	Age:	Gender:
	Name of Child:	
	Age:	Gender:
	Emergency Contacts (To be used if custodial parent cannot be reached, in the event of an emergency):	

Type of Service	Please check all that applies:
	<input type="checkbox"/> Supervised Access; <input type="checkbox"/> Access Exchange <input type="checkbox"/> Transportation Required; <input type="checkbox"/> Reports Required

Office Use Only	
Date Received:	Date Contacted: