State of Illinois
Department of Human Services - IMSHS

Transition Referral

Date: _____

Name and title: _____

Agency and address: _____

Dear colleague:

_____ enrolled _____

(Name of the parents) (Name of the child)

Date of Birth _____ at our Migrant Head Start Center, during the season _____

The child has been diagnosed with _____ and has been receiving special services

Because continuity of services is so important for this child, the parents have already authorized us to release the confidential information you may need (see attached). Please feel free to contact _____ at _____ , or you may call, Grantee Office, at 217-524-6318.

If we can be of any further assistance, please do not hesitate to contact us at the above numbers. Thank you for your time and cooperation.

Sincerely,