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| Date parent was notified of referral: | | | | | |  | | Date of Referral: | | | |  | |
| **Name of Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Perm ID#\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_ Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_ Language:\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If child lives with a parent please indicate which one: Circle parent child lives with: Father Mother Both or complete the caretaker info:**  **Caretaker/Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **School Attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_ Learning Facilitator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Referring Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Reason for Referral, (please be detailed):**  **If a TYSB request is required, has it been submitted to TYSB?**  **What interventions have been tried?**  **Does this case warrant it to be expedited for services? If so why?**  **Goal of the referring party: What do you hope Healthy Start can do to help this child and their family?** | | | | | | | | | | | | | |
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| **LIST OTHER CHILDREN IN THE HOME** | | | | | | | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | **Age:** | | **School:** | | | | **Perm ID#** |
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|  | | | | **Reason for Referral** | | | | | |  | | |  |
|  | Health Care | | |  | Education-Preschool/Special Ed support | | | | |  | Housing | | |
|  | Psychological/Mental Health (TYSB) | | |  | Parenting Skills | | | | |  | SARB/Expulsion | | |
|  | Basic Needs (Food & Clothing) | | |  | Finances | | | | |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | McKinney Vento | | |  | Known or suspected substance abuse | | | | |  | Domestic Violence | | |
|  | Pregnant/ Expected Due Date: | | |  | Pregnant Teen or Teen parent | | | | |  | Immigration | | |
|  | COVID - Hardship | | |  | Case Management | | | | |  | Paperwork/Applications | | |
|  | Foster Child | | |  | Aggressive behavior/Defiant | | | | |  | Resources linkage | | |
|  | Safe Care/Parenting Wisely | | |  | Family Services | | | | |  | Depression/Disorders/Anxiety (KV) | | |

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| **HEALTHY START OFFICE USE ONLY:**  **Date Received: Assigned to: Date Assigned:**  **Family ID# Prior Family ID # Prior Case Manager Assigned:** |
| Main Program Circle One: DR Pre DR Post Family Check Up First 5 General Healthy Families McKinney Vento PLAY | |
| Ancillary Program(Circle all that apply): Families Talking Together Parenting Wisely PAT Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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Revised 3/23/2022 LL & LL

Cont. reason of referral on next page

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| Cont. reason for Referral:  Confidential information: Is there anything you’d like us to know but don’t want us sharing with parents? |

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