|  |  |  |  |
| --- | --- | --- | --- |
| 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?** |
|  |  |
| **LIST OTHER CHILDREN IN THE HOME** |
| **Last Name:** | **First Name:** | **Age:** | **School:** | **Perm ID#** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|       |       |       |       |  |
|       |       |       |       |  |
|       |       |       |       |  |
|  | **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) |

|  |
| --- |
| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Page 2 of 2

Revised 3/23/2022 LL & LL

Cont. reason of referral on next page

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

Page 2 of 2