Referral for Home Visiting Services

CD Case Manager:		Date:
CD Contact Information:		
Parent Name:	DOB:	DCN:
Parent Name:	DOB:	DCN:
Household Address:		
Phone Number:	Cell Phone Number:	
E Mail Address:		
Child's Name:	DOB:	DCN:
Child's Name:	DOB:	DCN:
Child's Name:	DOB:	DCN:

Please mark all that apply to the family:

- ◯ Have a child less than three (3) years of age, prenatal services included
- ◯ Have a household income under 185% of poverty as defined at http://aspe.hhs.gov/poverty
- ◯ "At risk" for physical, emotional, social or educational abuse/neglect
  - o Newborn Assessment
- ◯ Family whose child is in the custody of DSS with an active plan for custody of the child to be returned to the family
- ◯ Living in a shelter or temporary housing
- ◯ Teenage parent
- ◯ Unemployed, but may be receiving Temporary Assistance or other income
- ◯ Employed 40 hours or less per week
- ◯ Participating in an education or job training program.

The Family's participation in a home visiting program is **voluntary**

Agency Family Referred to:	Date:	
Agency Contact Person:		
Family Accepted Home Visiting Services:	Yes:	No:
Comments:		

I authorize the Children's Division to discuss my case with the Home Visiting Agency I am being referred to. Parent's Signature: ____