Revised 06/11/2024

HEALTHY BEGINNINGS - ENTRY AGENCY REFERRAL

___PREGNANT MOM - Expected Delivery Date: ____________ ___POSTPARTUM MOM HMHB TELEPHONE #: 561-665-4500 FAX TO HMHB: 561-665-4545 EMAIL TO HMHB: info@hmhbpbc.org	___CHILD (Age 0 - 5) **If referring siblings, please complete one form per child** HOMESAFE TELEPHONE #: 561-383-9871 FAX TO HOMESAFE: 561-383-9859 EMAIL TO HOMESAFE: referral@helphomesafe.org

PARTICIPANT'S CONTACT INFORMATION:

(For referrals to HomeSafe, please note the participant is the child)

Participant Name: ____ Participant's Date of Birth: _______________

Gender: M or F Language(s) spoken: ____English ____Spanish ____Creole ____Other: ______________________

Participant's Phone #: __________________ Email: ____

Best time & day to contact: __________________________ Birth Hospital (*for infants only*):_________________________

Address: _______________________________________ City ________________________ Zip Code: ______________

Name of Parent/Guardian (if participant is under age 18): __________________ Relationship to Participant: _______________

REASON FOR REFERRAL:

____Suspected developmental delay or concern of child *(circle all areas of concern):*

Behavior Motor/Physical Cognitive Social/Emotional Speech/Language Other: ____________________

____Pregnant Mom Is this the client's 1st child? Y or N ____Postpartum Mom

____Unsafe Sleep ____Parenting Support ____Basic Needs ____Substance Exposed Infant

____Other (Describe): ____

REFERRAL SOURCE CONTACT INFORMATION:

Person Making Referral: ____ Date of Referral: _____________________

Agency/Program: ____ Supervisor: ____________________________

Contact Phone #: ____________________ Email: ____

If DCF is making this referral, provide the following: DCF Case #: ________________ DCF Intake #: __________________

REFERRAL SOURCE: Please collect the information below

Participant consents to be contacted about Healthy Beginnings programs and services via the following methods:
(check all that apply)

______Voicemails ______Text Messages ______Emails ______Mail ______Leave Materials

RELEASE OF INFORMATION CONSENT:

I, ____________________________________ (print name of participant or child's legal guardian), give my permission for ____________________________ (person making referral), to share any and all pertinent information regarding me or my child, ________________________ (print participant's name) with the Healthy Beginnings Entry Agency listed above, Children's Services Council of Palm Beach County (CSC), and any of its contracted co-funding entities and Service Providers. This authorization shall remain in effect unless withdrawn in writing.

Signature: ____ Date: ______________________

_______Client gave verbal permission for release of information/consent __________ Provider Initial