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: Select 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 *(check 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 This authorization shall remain in effect unless withdrawn in writing.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