Help Me Grow Sacramento Referral Form

916-822-8744 * Email: helpmegrow@warmlinefrc.org *Fax1-877-561-7523

First name: _____ **Middle initial:** _____ **Last name:** _____
Example: Monica *P* *Herrera-Lopez*

Address:_____
Example: 4343 C St. Sacramento,

Zip Code: _____
Email: _____ **Home Phone Number:** (_____) _____- _____
Cell Phone Number: (_____) _____- _____

Relationship to child:
☐ **Mother** ☐ **Father** ☐ **Grandparent** ☐ **Foster Parent** ☐ **Other Relative**

Child's Information ☐ *(check here if multiple children are being referred and complete the back side)*

First name: _____ **Middle initial:** _____ **Last name:** _____
Example: Monica *P* *Herrera-Lopez*

Date of birth: ____ /____/____ *(month/day/year)* **Sex:** ☐ Male ☐ Female

Age Group:
☐ Prenatal ☐ Birth-11 Mon. ☐ 1 Year ☐ 2 Years ☐ 3 Years
☐ 4 Years ☐ 5 Years ☐ Unknown

Race/Ethnicity: *(Check all that apply)*
☐ Alaska Native/ American Indian ☐ Black/ African American ☐ Hmong ☐ Russian/ Ukrainian ☐ Multiracial
☐ Asian ☐ Hispanic/Latino ☐ Pacific Islander ☐ White ☐ Other: _____

Language most comfortable with: *(select ONLY one)*
☐ English ☐ Cantonese ☐ Vietnamese ☐ Russian/Ukrainian
☐ Spanish ☐ Mandarin ☐ Hmong ☐ Other: _____

What type of health insurance does your child have?
☐ No insurance ☐ Medi-Cal ☐ Other Insurance _____ ☐ Don't know if child has insurance

Enrolled in childcare/preschool? ☐ **Yes** (Name of program _____) ☐ **No**

In the past year, has your child received a developmental screening? ☐ **Yes** ☐ **No**

Reason for referral/request for services: *(check all that apply)*
☐ ASQ Results ☐ ASQ-SE Results ☐ Parental Concerns ☐ Teacher/Child Care Provider Concerns ☐ Physician Concerns ☐ Other: _____

Area of concern: *(check all that apply)*
☐ Developmental concerns
☐ Physical health concerns
☐ Socio-emotional/behavioral concerns
☐ Social and economic concerns
☐ General information on HMG
☐ Other: _____

I give my permission for the release of my contact information and screening results (if applicable) to Help Me Grow Sacramento. I understand that all information provided is confidential.

Signature: _____ Date ____ /____/____ *(month/day/year)*

Referring agency information: *(please print)* ☐ check if First 5 Contractor Agency Name: _____

Agency Staff Name: _____ Email: _____Phone number: _____

For HMG Program Staff Only: Date Entered In Persimmony_____/____/_____ By _____ Follow Up Date _____/____/_____

First name: _____ **Middle initial:** _____ **Last name:** _____
Example: Monica *P* *Herrera-Lopez*

Date of birth: ___ /___/___ *(month/day/year)* **Sex:** ☐ Male ☐ Female

Age Group:

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What type of health insurance does your child have?

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In the past year, has your child received a developmental screening? ☐ **Yes** ☐ **No**

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Reason for referral/request for services: *(check all that apply)*

☐ ASQ Results ☐ ASQ-SE Results ☐ Parental Concerns ☐ Teacher/Child Care Provider Concerns ☐ Physician Concerns ☐ Other: _____

Area of concern: *(check all that apply)*

☐ Developmental concerns
☐ Physical health concerns
☐ Socio-emotional/behavioral concerns
☐ Social and economic concerns
☐ General information on HMG
☐ Other: _____

Agency Staff only: This section REQUIRED for Family Advocate Referrals. Provide as much information as possible below.

Reason for referral/request for services (detail):

Additional information (e.g. cultural issues, physical problems, CPS involvement, transportation issues, name of school, etc.)