RESET

Referral for Home Visiting Services

CD Case Manager:		Date:
CD Contact Information (Phone Number and Email Address):		
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:

The following criteria must be met:

- ◯ 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

Please mark any additional criterion that applies:

- ◯ "At risk" for physical, emotional, social or educational abuse/neglect
- ◯ 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.

Current Case Status:

___ Investigation ___ Assessment ___ Newborn Crisis Assessment (NCA)
___ Family Centered Services (FCS) ___ Alternative Care (AC) ___ Intensive In-Home Services (IIS)

***If family is being transferred from an open CA/N report to a FCS/AC case and the FCS/AC case manager is not the referring party, please include contact information for FCS/AC case manager.

Any Safety Concerns:_____

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

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