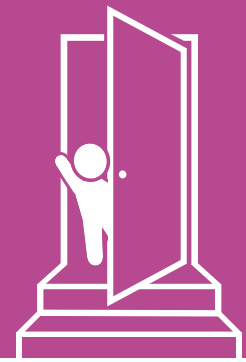




# HOME VISITING REFERRAL FORM



Complete this form and fax it to 302-295-5988 or email [Helpmegrow@uwde.org](mailto:Helpmegrow@uwde.org). Potential clients can self-refer by calling 2-1-1 or texting their ZIP code to 898-211.

\_\_\_\_\_ (DATE OF REFERRAL) FIELDS MARKED WITH \* ARE REQUIRED

\_\_\_\_\_ (CLIENT NAME)\* \_\_\_\_\_ (DATE OF BIRTH)\*

\_\_\_\_\_ (ESTIMATED DUE DATE) \_\_\_\_\_ (EMAIL ADDRESS)\*

\_\_\_\_\_ (ADDRESS)

\_\_\_\_\_ (ADDRESS 2)

\_\_\_\_\_ (CITY) \_\_\_\_\_ (ZIP)\* \_\_\_\_\_ (PREFERRED PHONE)\* **Landline** **Cell**

\_\_\_\_\_ (NAME) \_\_\_\_\_ (ALTERNATE PHONE) **Landline** **Cell**

### Preferred Method of Communication\*

Client prefers text      Client prefers phone call      Client prefers email

\_\_\_\_\_ (DAYS/TIMES THAT WORK BEST)

\_\_\_\_\_ (CHILD NAME) \_\_\_\_\_ (CHILD DATE OF BIRTH)

**Primary Language\***    English    Spanish    Creole    Other: \_\_\_\_\_ (OTHER LANGUAGE)

**Race\***    African American    Asian    Biracial    Caucasian    Hawaiian / Pacific Islander

Latinx    Native American    Other: \_\_\_\_\_ (OTHER ETHNICITY/RACE)

## REFERRING PERSON\*

Self  
Agency

\_\_\_\_\_ (NAME OF PERSON)

\_\_\_\_\_ (PHONE)

\_\_\_\_\_ (EMAIL)

\_\_\_\_\_ (AGENCY)

### If referral is under 18:

\_\_\_\_\_ (PARENT OR LEGAL GUARDIAN)

Is it OK to contact this person in reference to this referral?

Yes      No

\_\_\_\_\_ (PHONE)

### Potential Risk Factors to Consider for Making a Referral\* (please check those that apply):

- |  |                                    |   |
|--|------------------------------------|---|
| Teen parent                                      | Low income                         | Death in the immediate family                   |
| Child w/ disability or chronic health condition  | Recent immigrant or refugee family | Foster care or other temporary caregiver        |
| Parent w/ disability or chronic health condition | Substance use disorder             | Military deployment                             |
| Parent w/ mental health issue(s)                 | Housing instability                | Parent incarcerated during the child's lifetime |
| Low educational attainment                       | Very low birth weight              |   |
|  | Intimate partner violence          |   |
|  | Child abuse or neglect             |   |

Is the client being referred involved with DFS?	Yes	No
If yes, is there a plan of safe care (POSC) in place?	Yes	No

