



CHILD AND FAMILY SERVICES
Healthy Families Program
Referral Form

Date of referral
Referral source
Phone No:

Mother's Name: D.O.B.

Address: Phone No.

Father's Name: D.O.B.

Address: Phone No.

Currently Pregnant? Yes/No Trimester Due Date

Medicaid #: Mother Physician:

Address:

Phone No:

How is family supported?

- TANF Cash Assistance Work hours/week Who works?

Ways this program can benefit a family:

- Learn more about pregnancy and parenting
Learn more about child development
Find other pregnant and/or new moms to talk to and hang out with
Find a playgroup for my child
Have a doctor/health care provider that I can go to when I am sick OR for prenatal care
Have a doctor /health care provider that I can take my child to for immunizations AND when my child is sick
Nutritious foods
Reliable transportation
Have health insurance for my child/ and myself
Learn more about breastfeeding.
Get a better job
Go back to school
Find safe high quality childcare that I can count on
Maternity/nursing clothes
Clothes for the baby
Books for the baby
A better apartment/housing
A pregnancy journal to keep track of appointment, doctor notes, etc.

Priority Consideration

- Under age 25 Smoker
1 or more children under 3 years
Same father Different father
Education below 10th grade
Homelessness
Mental health concerns
Lack of Prenatal care
Substance abuse:
Self Partner
History of domestic violence:
Current Past
Other

For Office Use Only:
Home Visitor:
Nurse:
Date Assigned:
First Home Visit: