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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Worker Safety Alert | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EightCAP, Inc. 0-5 Head Start  **Referral Form**  *0-5* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: | |  | | | | | | | | | | | | County: | | | |  | | | | | | | | | | | |
| Bio Parent/Guardian Name: | | | | | | | | |  | | | | | | | | | | | Birth Date: | | | | |  | | | | |
| Bio Parent Address: | | | | | |  | | | | | | | | | | | | | | | | Phone: | | | |  | | | |
| Childs Name: |  | | | | | | | | | | | | | | | | Birth Date: | | | |  | | | | | | | | Sex  M  F |
| Childs Name: |  | | | | | | | | | | | | | | | | Birth Date: | | | |  | | | | | | | | Sex  M  F |
| Foster Care  yes  no Program(s) applying for:  **Head Start** (ages 3-5) and/or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Early Head Start** (prenatal moms and children ages 0-3)  Home Based  Center Based (not available in Montcalm) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Foster Parent Name: | | | | | | |  | | | | | | | | | | | | | Phone: | | |  | | | | | | |
| Foster Parent Address: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| How long in foster care? | | | | | | | |  | | | | Would foster parents allow visits in home? | | | | | | | | | | | | | | | | Yes  No | |
| County visits take place: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Any conviction that prevent parents from being on school property or around children? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes No | | |
| Please explain: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please list reasons family would benefit from intensive services and relevant information. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the child or parent involved with: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health: | | | | | | | Agency: | | | |  | | | | | | | | Case Manager: | | | | |  | | | | | |
| Early On: | | | | | | | Yes  No | | | | | | Case Manager: | | |  | | | | | | | | | | | | | |
| IDA: | | | | | | | Yes  No | | | | | | Date: | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check all that apply: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Infant/child drug-exposed  Teenage Parent (under 20 when 1st child born)  Parent with serious mental disturbance  Parent with substance abuse or addiction  Parent with destructive/violent temperament  Family with Special Needs  Infant/Toddler diagnosed Failure to Thrive | | | | | | | | | | | | | | Domestic violence  Child developmentally delayed  Family history of child abuse  Premature birth  History of mental illness  Poor parenting skills | | | | | | | | | | | | | | | |
| Case Worker: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Number: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Email address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency referring: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Please fax: 616-754-9310 or email to Denise at [deniseb@8cap.org](mailto:deniseb@8cap.org) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Please include an Early/Head Start Application if possible. Application can be found at www.8cap.org | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

5/3/16 AB ERSEA: ERSEA