HELP ME GROW OF CUYAHOGA COUNTY REFERRAL FORM

Complete and return to: Help Me Grow / 8111 Quincy Avenue, Suite 344, Cleveland, OH 44104 / Fax: (216) 391-6106 / OhioReferrals@HelpMeGrow.org

CHILD INFORMATION (Please complete one form for each child)

Child's name: _____
Last First Middle

Child's DOB or Due Date: ____ / ____ / ____ Gender: ❒ M ❒ F

❒ Check if referring multiple children per caregiver

Contact us today for more information or to enroll:

(216) 698-7500

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian's Name: _____
Last First Middle

Parent/Guardian's DOB: ____ / ____ / ____

Relationship: ❒ Mother ❒ Father ❒ Foster Parent ❒ Grandparent
❒ Other: _____

Primary Phone #: ( ) _____ - _____ ❒ Accepts texts

Secondary Phone #: ( ) _____ - _____ ❒ No phone

Email: _____

Address: _____

City: _____ State: ____ Zip: _____

Primary Language: ❒ English ❒ Spanish ❒ Other:_____

Interpreter required? ❒ Yes ❒ No

Other Parent/Guardian/Involved Person:

_____
Last First Middle

Other Parent/Guardian/Involved Person's DOB: ____ / ____ / ____

Relationship: ❒ Mother ❒ Father ❒ Foster Parent ❒ Grandparent
❒ Other: _____

Primary Phone #: ( ) _____ - _____ ❒ Accepts texts

Secondary Phone #: ( ) _____ - _____ ❒ No phone

Email: _____

Address: _____

City: _____ State: ____ Zip: _____

REASON FOR REFERRAL

❒ Child has a suspected delay in one or more areas of development or has medical diagnosis/es that could affect development. Please describe:

_____
_____
_____

❒ Pregnant first-time mother, or first-time mother of a child under 6 months old, with family income less than or equal to 200% of federal poverty level.

❒ Family has other factors that may place the child at a higher than average risk for developmental delay. Check all that apply:

❒ Adolescent parent (age 20 or under)
❒ Single parent
❒ First time parent
❒ Low income
❒ Parent with history of abuse or neglect
❒ Parent with history of domestic violence
❒ Parent with a mental health diagnosis
❒ Parent with a developmental delay
❒ Lack of stable residence / homelessness
❒ Dangerous living conditions
❒ Parent with drug or alcohol dependence
❒ Maternal prenatal substance abuse

❒ Other reason for referral, please describe:

_____
_____
_____

REFERRAL SOURCE INFORMATION

Referred by: _____ Email: _____

Referring agency: _____ Date of referral: ____ / ____ / ____

Phone #: ( ) _____ - _____ Fax #: ( ) _____ - _____

Address: _____ City: _____ State: ____ Zip Code: _____

Referral requested by/on behalf of: _____
(Include name of person requesting referral, such as physician, healthcare worker, child care provider, etc.)

Email: _____

❒ Check if family is involved with another home visiting program If so, which one? _____

Help Me Grow is a statewide voluntary child development program that provides services to eligible families with young children up to the age of three.
For more information, please visit our website at helpmegrow.org

Effective 1/15/15