



Washington County Prenatal and Birth to 3 Services

REFERRAL / INTAKE FORM

Part I to be completed by referring entity and forwarded by fax or mail to:

Help Me Grow
202 Davis Avenue
Marietta, OH 45750

Phone: 374-4954 or Toll-free 1-877-374-4954
Fax: 740-376-7084
email: fcfc@suddenlinkmail.com

Today's Date _____ Person making referral _____

Referring Entities Affiliation (agency name; physician; school) _____

Your Address _____

Your phone # _____ Fax # _____ Is family aware of referral? _____

Child's name _____ D.O.B. _____ Male or Female? _____

If referral is for a *Prenatal Mom*, identify due date: _____

Parent/Guardian/**Mother's** Name: _____

Parent/Guardian/**Father's** Name: _____

Parent/Guardian's Address _____

City _____, Ohio Zip _____

Phone number: Home _____ Work _____ Cell _____

Reason for Referral: _____ First-Time Prenatal Mom [Under 200% FPL? ___ Yes ___ Unsure]

_____ First-Time Parent with Infant under 6-months of age [Under 200% FPL? ___ Yes ___ Unsure]

_____ Child has a medical diagnosis: List _____

_____ The Parent of the child (birth to age 3) is engaged in active military duty.

_____ Re-enrollment (child previously eligible for HMG) _____

_____ Concern for child's development. Please list area(s) of concern(s): _____

Part II completed by Help Me Grow

Date referral received by HMG: _____ 45-Day Timeline _____

Person taking referral _____ Date Initial letter sent to family _____

SC or HV assigned: Name _____ Date _____

Entered in ET: Date _____ by (initial) _____ Enrollment Date: _____

Income verified by: ___ WIC ___ Medicaid ___ OWF ___ Self-Report Income NOT verified at referral _____