|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **MISSOURI DEPARTMENT OF SOCIAL SERVICES**  **CHILDREN’S DIVISION**  **HEAD START/EARLY HEAD START REFERRAL FORM** | | | | | | |  | | | |
|  |  | | | | | | | **Date:** |  | | |
|  |  | | | | | | |  | | | |
| **Purpose:** This form is to be used staff to refer a child to Head Start (HS)/Early Head Start (EHS) program. While children in foster care are categorically eligible for HS/EHS services, this form does not guarantee a placement slot. This form is designed to ensure pertinent information is made available to HS/EHS in a consistent manner. | | | | | | | | | | | | |
| Child’s Name | | | | | DOB | | | | | DCN | | |
|  | | | | |  | | | | |  | | |
| Parent/Guardian Name | | | | | | | | | | | | |
|  | | | | | | | Biological  Foster  Resource | | | | | |
| Parent/Guardian Phone | | | | Parent/Guardian Email | | | | | | | | |
|  | | | Cell  Home |  | | | | | | | | |
| Parent/Guardian Address (Address, City, State, Zip) | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| If Foster/Resource Parent Above, Biological Parent Name | | | | Biological Parent Phone | | | | | | | | |
|  | | | |  | | | | | | | Cell Home | |
| Children’s Division Worker Name | | | | Supervisor Name | | | | | | | | |
|  | | | |  | | | | | | | | |
| Children’s Division Worker Email | | | | Children’s Division Worker Phone | | | | | | | Best Way to Contact | |
|  | | | |  | | | | | | | Email  Phone | |
| **Services Needed** | | | | | | | | | | | | |
| Early Head Start (Birth – 3 years)  Head Start (3 – 5 years) | | | | | | | | | | | | |
| Other resources (explain in additional information section) | | | | | | | | | | | | |
| **Referral Information** | | | | | | | | | | | | |
| TANF/SSI | | | Homeless | | | Foster Child/Kinship Care | | | | | | |
| Open Children’s Division Case  Alternative *Care*  *Family Centered Services* | | | *Intact Family*  *Open Hotline* | | | Eligible to receive child care assistance | | | | | | |
| **Head Start/Early Head Start Results** (to be completed by Head Start staff) | | | | | | | | | | | | |
| Referral Received Date: | |  | | | | | | | | | | |
| Children’s Division Follow-up Date: | |  | | | | | | | | | | |
| Family Contact Date: | |  | | | | | | | | | | |
| Program Option Referred To: | |  | | | | | | | | | | |
| Site Referred To: | |  | | | | | | | | | | |
| Application taken: | |  | | | | | | | | | | |
| Enrolled/Waitlisted: | |  | | | | | | | | | | |
| Head Start Staff Name | | | | Supervisor Name | | | | | | | | |
|  | | | |  | | | | | | | | |
| Head Start Staff Email | | | | Head Start Staff Phone | | | | | | | Best Way to Contact | |
|  | | | |  | | | | | | | Email  Phone | |
| **Additional Information** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

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| --- | --- | --- |
|  |  |  |
| Parent Signature |  | Date |