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|  | **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 |