RESET

Referral for Home Visiting Services

CD Case Manager:		Date:
CD Contact Information: (Phone Number and Email Address)		
Parent Name:	DOB:	DCN:
Parent Name:	DOB:	DCN:
Household Address:		
Phone Number:	Cell Phone Number:	
E Mail Address:		
Child's Name:	DOB:	DCN:
Child's Name:	DOB:	DCN:
Child's Name:	DOB:	DCN:

The following criteria must be met:

- ☐ Have a child less than three (3) years of age, prenatal services included
- ☐ Have a household income under 185% of poverty as defined at http://aspe.hhs.gov/poverty

Please mark any additional criterion that applies:

- ☐ "At risk" for physical, emotional, social or educational abuse/neglect
- ☐ Family whose child is in the custody of DSS with an active plan for custody of the child to be returned to the family
- ☐ Living in a shelter or temporary housing
- ☐ Teenage parent
- ☐ Unemployed, but may be receiving Temporary Assistance or other income
- ☐ Employed 40 hours or less per week
- ☐ Participating in an education or job training program.

Current Case Status:

☐ Investigation ☐ Assessment ☐ Newborn Crisis Assessment (NCAT)

☐ Family Centered Services (FCS) ☐ Alternative Care (AC) ☐ Intensive In-Home Services (IIS)

***If family is being transferred from an open CA/N report to a FCS/AC case and the FCS/AC case manager is not the referring party, please include contact information for FCS/AC case manager.

Any Safety Concerns:

The Family's participation in a home visiting program is **voluntary***

I authorize the Children's Division to discuss my case with the Home Visiting Agency I am being referred to.

Parent's Signature:

SUBMIT