



## Ohio Help Me Grow Child Information and Referral Data Collection form

ET ID: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Child Demographic Information:

<b>*Child's Last Name</b>		<b>**Child's First Name</b>		Child's Middle Name	
<b>** Birth Date</b> ____/____/____	<b>** Due Date</b> ____/____/____	Child SSN - -	<b>** Sex</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>** Ethnicity</b> <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Cuban	<input type="checkbox"/> Hispanic <input type="checkbox"/> Mexican/ Mexican American/ Chicana <input type="checkbox"/> Other Hispanic/Latino <input type="checkbox"/> Puerto Rican
<b>** Race</b>		<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Unknown (must pick at least one other)	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian or Chomorro	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Japanese				

### Primary Caregiver Information

Does the primary caregiver have other children in HMG? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*Primary Caregiver Last Name</b>	<b>*Primary Caregiver First Name</b>	Primary Caregiver Middle Name		
Primary Caregiver Birth Date ____/____/____	Primary Caregiver SSN - -	<b>*Primary Caregiver Primary Phone</b> <input type="checkbox"/> No phone	Primary Caregiver Secondary Phone		
<b>*Relationship to Child</b>	<input type="checkbox"/> Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grand Parent	<input type="checkbox"/> Other Caregiver <input type="checkbox"/> Step Parent <input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Surrogate Parent	<b>*Primary Language</b>	Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>*Street Address Line 1</b>	<b>*Street Address Line 2</b>	<b>*City</b>	State <b>OH</b>	<b>*Zip Code</b>	

### Other Caregiver Information

Does this caregiver have other children in HMG? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Caregiver Last Name	Other Caregiver First Name	Other Caregiver Middle Name		
Other Caregiver Birth Date ____/____/____	Other Caregiver SSN - -	Other Caregiver Primary Phone <input type="checkbox"/> No Phone	Other Caregiver Secondary Phone		
Relationship to Child	<input type="checkbox"/> Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grand Parent	<input type="checkbox"/> Other Caregiver <input type="checkbox"/> Step Parent <input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Surrogate Parent	Primary Language	Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address Line 1	Street Address Line 2	City	State	Zip Code	

### Referral Information:

<b>*Date of Referral</b> ____/____/____	<b>*Referral Source Type</b>	<input type="checkbox"/> GRADS Program <input type="checkbox"/> Head Start <input type="checkbox"/> Help Me Grow <input type="checkbox"/> Hospital <input type="checkbox"/> Hospital Child Find Specialist <input type="checkbox"/> Human Services <input type="checkbox"/> LEAP	<input type="checkbox"/> Legal <input type="checkbox"/> Local Health Dept. <input type="checkbox"/> Local Preschool <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> County Board of DD <input type="checkbox"/> Nonprofit Com. Provider <input type="checkbox"/> OCCSN <input type="checkbox"/> ODH BCMH	<input type="checkbox"/> Physician <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Public School <input type="checkbox"/> Regional Infant Hearing <input type="checkbox"/> State Health Dept <input type="checkbox"/> WIC	
<b>**Referrer Name</b>	<b>*Referral To Category</b> <input type="checkbox"/> Suspected H.V. Elig. <input type="checkbox"/> Suspected Part C <input type="checkbox"/> Unknown	<b>**Referral Source Name</b>	Referrer Email	<b>*Referrer Phone</b> <input type="checkbox"/> No Phone	Referrer Fax
<b>**Referrer Street Address Line 1</b>	<b>**Street Address Line 2</b>	<b>**Referrer City</b>	<b>**State</b>	<b>**Referrer Zip Code</b>	
Referral Reason	Beyond this point office use only >>	<b>*Referral Contact Date:</b> ____/____/____	<b>*Referral Contact Method:</b> <input type="checkbox"/> In person <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> No Contact	<b>*Contact Outcome</b> <input type="checkbox"/> Response <input type="checkbox"/> Mailed <input type="checkbox"/> No Response Info	
<b>**Referral Outcome Date</b> ____/____/____	<b>**Referral Outcome</b>	<input type="checkbox"/> Child/family referred w/in 45 days of 3 <sup>rd</sup> birthday <input type="checkbox"/> Child/family could no longer be located	<input type="checkbox"/> Family not interested <input type="checkbox"/> Child/family not eligible for Home Visiting Program		

**\*Required**

**\*\*Conditionally Required**

*Use of this form is required and it must be kept in child records.*

Created: June 2010

**Logan County's Birth to Three Services – Central Intake & Referral**

In order for our Central I&R staff to best determine which services the family may be eligible for, please check ALL that apply. Someone will then contact the family to advise them of any additional services they may be eligible for.

- First time parent (either mother and/or father)
- Teen parent (under age 20)
- Mother is prenatal
- Child is under 6 months of age
- Child is a newborn less than 6 weeks old (check all that apply)
  - Late pre-term baby – born at 34-37 weeks gestation
  - Baby is/was transferred to level 3 hospital
  - Maternal history of alcohol or other drug use
  - Fewer than 5 prenatal visits (includes no prenatal care)
  - Community report (including CSB) to hospital for concern of child's well-being
  - Maternal history of mental health concerns
  - Developmental or physical disability of mother
  - Presence of other medical conditions of the mother/child
- Significant concern regarding child's development (please check on of the following)
  - A developmental screening has been done and indicates possible delay
  - No recent developmental screening completed
- Child has a medical condition that will likely result in a developmental delay What is it? \_\_\_\_\_
- Low income – Family receives some form of public assistance such as Medicaid, food stamps, WIC, etc.
- Family is currently or has been enrolled in Help Me Grow in the past. If so, what county? \_\_\_\_\_
- Family is currently enrolled in Early Head Start Services
- Parent is in active military duty
- Family has multiple social service needs

**Thank you for your referral to Logan County Birth-3 Services.**

**Submit Referral information to**

Project Child/ Help Me Grow  
 PO Box 710, Bellefontaine, OH 43311  
 937-292-3041 (phone)  
 937-592-7001 (fax)  
[ssnyder@logancbdd.org](mailto:ssnyder@logancbdd.org)

**OFFICE USE ONLY**

Potential referrals to services the family may be eligible for	Date referral made	Family declined referral	Staff Initials
<input type="checkbox"/> Newborn Home Visit (LCHD) <input type="checkbox"/> OCTF/ FCFC NBHV <input type="checkbox"/> EHS NBHV (only if enrolled EHS)			
<input type="checkbox"/> Early Head Start Home Visiting (CORS)			
<input type="checkbox"/> Help Me Grow <input type="checkbox"/> Part C (LCBDD) Service Coordinator Assigned: _____ <input type="checkbox"/> Home Visiting (CORS) <input type="checkbox"/> Home Visitor Assigned: _____			
<input type="checkbox"/> Child Find			