MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – HOME VISITING

REFERRAL FORM – SAFE CRIBS PROGRAM

INSTRUCTIONS

To be completed by Local Public Health Agency or authorized contractor only.
FAX the completed form to:573-751-6185
EMAIL the completed form to: Office of Childhood-Home Visiting at HomeVisiting@dese.mo.gov.
MAIL the completed form to: Missouri Department of Elementary and Secondary Education, Office of Childhood-Safe Cribs Program, PO Box 480, Jefferson City, MO 65102.

QUESTIONS: Contact the Office of Childhood-Home Visiting at 573-522-2355

CLIENT INFORMATION

CLIENT'S FIRST NAME	LAST NAME	MAIDEN NAME	CLIENT'S DATE OF BIRTH	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

ETHNICITY

Hispanic or Latino ☐ Not Hispanic or Latino ☐

RACE

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Multiracial ☐ Don't Know ☐ Refused ☐ Other:

EDUCATIONAL LEVEL

Some high school ☐ High school diploma/GED ☐ 2-year community college ☐ 4-year college graduate ☐ Graduate school ☐ Unknown ☐ Other (please explain):

ELIGIBILITY REQUIREMENTS

The client is currently:

☐ Prenatal — Gestational Age (weeks):
☐ Postpartum — Baby's Date of Birth: — Baby's Full Name:

Financial Eligibility for program:

WIC recipient ☐ Medicaid ☐ 185% of poverty or less ☐ Does client have health insurance or Medicaid? Yes ☐ No ☐

Does client already have any of the following in their home?

Bassinet No ☐ Yes ☐ Full-Size Crib No ☐ Yes ☐ (explain): Portable Crib No ☐ Yes ☐ (explain):

CLIENT ASSESSMENT

If you do not receive a crib from this program, what are the sleeping arrangements for your baby?

Alone in a full-size crib ☐ Alone in a portable crib ☐ In client's bed with others ☐ In bed with others ☐ Alone in a bassinet ☐ Sofa or chair ☐ Other (specify):

If using a bassinet, what are your plans once the baby outgrows it? NA ☐

Alone in a full-size crib ☐ Alone in a portable crib ☐ In client's bed with others ☐ In bed with others ☐ Alone in a bassinet ☐ Sofa or chair ☐ Other (specify):

Where did you hear about the Safe Cribs program? (check all that apply)

County Health Department ☐ Media/News/Radio/Internet ☐ Doctor/Health Center ☐ Flyers/Brochures/Posters ☐ Friend(s) ☐ Family/Relative ☐ WIC ☐ Other (specify):

AGREEMENT FOR REFERRAL

I agree to allow _____ County Local Public Health Agency to provide my referral to the Safe Cribs Program to obtain a portable crib for my baby. I agree to a home visit 4 to 6 weeks after my baby is born or after I receive the crib. I agree to participate in two Safe Sleep education sessions with at least one being in my home. I am unable to afford a crib without the assistance of this program and have no other place to obtain one.

CLIENT'S SIGNATURE	DATE

REFERRING AGENCY	AGENCY CONTACT PERSON'S NAME	E-MAIL ADDRESS	PHONE NUMBER

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