



REFERRAL FOR HOME VISITING SERVICES

INSTRUCTIONS

Please fill out form completely and send to HomeVisiting@dese.mo.gov

REFERRAL INFORMATION

| | | |
|-------------------------|--------------------------|------|
| REFERRING PERSON | | DATE |
| REFERRER'S PHONE NUMBER | REFERRER'S EMAIL ADDRESS | |
| PARENT/CARETAKER NAME | DATE OF BIRTH | |
| PARENT/CARETAKER NAME | DATE OF BIRTH | |
| HOUSEHOLD ADDRESS | | |
| PHONE NUMBER | CELL PHONE NUMBER | |
| EMAIL ADDRESS | | |
| CHILD'S NAME | DATE OF BIRTH | |
| CHILD'S NAME | DATE OF BIRTH | |
| CHILD'S NAME | DATE OF BIRTH | |

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>

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 CHILDREN'S DIVISION STATUS (if known)

- | | | |
|---|--|---|
| <input type="checkbox"/> Investigation | <input type="checkbox"/> Assessment | <input type="checkbox"/> Newborn Crisis Assessment (NCA) |
| <input type="checkbox"/> Family Centered Services (FCS) | <input type="checkbox"/> Alternative Care (AC) | <input type="checkbox"/> 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****

PARENT /CARETAKER SIGNATURE **REQUIRED**

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