EARLY/HEAD START REFERRAL FORM

Head Start and Early Head Start programs provide services for low-income families with children ages birth to 5 years old as well as pregnant women at no cost. Early/Head Start programs enhance children's physical, social, emotional, and intellectual development; assist pregnant women to access comprehensive prenatal and postpartum care; support parents' efforts to fulfill their parental roles; and help parents move toward self-sufficiency. Please use this form to refer families that may benefit from these services. We will use the information provided to recruit eligible children for enrollment.

Child's Name: ______________________________ Date of Birth: ______________

Mother's Name: ______________________________ Living with Child? ☐ **Yes** ☐ **No**

If pregnant when is the due date: ________ Is this person receiving prenatal services? ☐ **Yes** ☐ **No**

Father's Name: ______________________________ Living with Child? ☐ **Yes** ☐ **No**

Home Phone#:____________________ Cell Phone#:____________________

Mailing Address: ______________________________City: ____________Zip: ________

Please indicate any/all programs in which the family is currently enrolled:

❑ Medicaid ❑TANF ❑ WIC ❑ SSI ❑ Foster Care ❑ Families United

❑ Early Intervention Colorado (Part C) ❑ Community Infant Child Program (CICP)

❑ Nurse Family Partnership ❑ Community Child Care ❑ Summit School District Preschool

Eligible families will be selected for enrollment in Early Head Start based on a variety of factors.

Please indicate any factors that you wish to be considered in the selection process below:

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By signing this document I affirm that I am authorized to provide Summit County Early / Head Start with the personal information about the individual(s) listed above.

____________________ ____________________ __________

Referring Party Name Signature of Referring Party Date

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Referring Agency Name and Contact Information