SUMMIT HEAD START 0-5 REFERRAL FORM

Summit Head Start 0-5 programs provide services for low-income families with children birth to 5 years old. Summit Head Start 0-5 enhances children's physical, social, emotional, and intellectual development; supports parents' efforts to fulfill their parental roles; and helps 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:________________ Was child premature? ☐Yes ☐No
If pregnant when is the due date? ___________________Receiving prenatal services? ☐ Yes ☐No
Preferred language: ________________ Mother's Name: _________________________DOB: ___________________
Lives with child? ☐ Yes ☐No Email: ___________________________ Cell Phone: ____________________________
Physical Address: ____________________________City: __________________Zip: ______________
Father's Name: _____________________________ DOB: ____________________ Living with child? ☐Yes ☐ No
Email: _____________________________________ Cell Phone: _____________________________
Physical Address: __________________________City: ______________________Zip: __________________

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

❑Medicaid ❑TANF ❑WIC ❑SSI ❑CCCAP ❑Foster Care ❑Building Hope ❑FIRC ❑SNAP
❑Early Intervention Colorado (Part C) ❑SPK/SFS Tuition Assistance ❑Strengthening Families (SFO)
❑Nurse Family Partnership ❑Community Child Care ❑Summit School District Preschool
❑Other:_______________________

Eligible families will be selected for enrollment in Early Head Start or Head Start based on a variety of risk 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 Head Start 0-5 with the personal information about the individual(s) listed above.

______________________	______________________	__________
Referring Person Name	Signature of Referring Person	Date

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Referring Agency Name and Contact Information (phone a/o email)

Please email this form to Dulce Hernandez with Summit Head Start at dulce@earlychildhoodoptions.org
Please feel free to call Dulce with questions at (cell) 970 368 3120 or (office) 970 406 3063.

For HS Office Use: Status as of one month from referral date: ______________________________

Date child started in EHS or HS: ______________________________

Add 'l. Notes: ______________________________

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