



Participant Name:	_____
Identification #:	_____
Clinic #:	_____

Local HANDS Agency Information	
Agency Name: _____	
Contact Person: _____	
Phone: _____	Fax: _____
Email: _____	

HANDS is a voluntary program for all families. Babies deserve safe, healthy, and happy childhoods, and we can support you in reaching this goal. This referral is the first step to help determine if HANDS might be a good fit for your family. Enrollments must occur within 90 days of baby's birth.

Parent/Legal Guardian Information			
First Name:	MI:	Last Name:	SSN:
Previous HANDS Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Address:			
City:	Zip:	County of Service:	
Primary Phone: () _____	Leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Text? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Alternate Phone: () _____	<input type="checkbox"/> N/A Leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Text? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Relationship to Baby: <input type="checkbox"/> Birth Mother <input type="checkbox"/> Birth Father <input type="checkbox"/> Guardian/Custodian other than birth parent			
Estimated Date of Delivery (complete for prenatal AND postnatal):			
Delivery Date (if applicable):		Baby's Name (if applicable):	
What primary language is spoken in the home?			Is an interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No

Referral Information
Date of Referral: _____
Please select how the participant learned about HANDS or which type of agency you represent from the list below.
<input type="checkbox"/> Church/Community Organization <input type="checkbox"/> Community Based Services <input type="checkbox"/> Family Resource Center/School <input type="checkbox"/> Family/Neighbor/Friend <input type="checkbox"/> Head Start <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital <input type="checkbox"/> OB/GYN <input type="checkbox"/> Other (List) _____ <input type="checkbox"/> Physician <input type="checkbox"/> Self-Referral

Referral Source
If this is not a self-referral, please complete the following information.
Name: _____ Agency: _____
Phone and/or Email: _____
Does the family know you are making a referral on their behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please return completed referral to your local HANDS Program via the contact information listed above.

