

## HEALTHY FAMILIES CONNECTION- Referrals

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The Center for Healthy Families through its Healthy Families Connection program offers holistic services for pregnant and parenting teens and their children. Services ranging from prevention to intervention are customized and based on the strengths of the participant, creating a system of support in order to move a young family forward.

We recognize that you and other professionals in education, government and health services have many options with the choice of human service providers. At the Center for Healthy Families, we are committed to working with you as we maintain high quality services. We maintain a continuum of care that focuses on pregnant and parenting teens and their children as our number one priority, and ensures their services with the Center for Healthy Families programs are transformative and successful.

### The Center for Healthy Families Intake Contact Information

Agencies may contact us at any time to refer a pregnant and/or parenting teen to our program. Please contact our staff by phone or e-mail as listed below.

Melanie Hill, Resource Advocate  
614.884.4205 direct office/ 614.884.4201 fax  
[melanie.hill@centerforhealthyfamilies.org](mailto:melanie.hill@centerforhealthyfamilies.org)

- Purpose:** Completion of this form occurs at the time of referral and is required to document a referral to the Healthy Families Connection Collaborative. Part I can be completed by a referral source outside of CHF-HFC and forwarded to CHF-HFC, or it can be completed by a CHF-HFC staff representative. CHF-HFC staff only may complete Part II.
- Part I – To gather identifying information and required referral information for a pregnant and/or parenting teen at the time of referral to the Healthy Families Connection.
- Part II – To document the eligibility determination decision with required staff signatures.
- Instructions:** In Part I, enter the requested information. In the event that a question does not apply or there is no answer to a question, leave the line blank. Make all attempts to answer as completely as possible. At minimum, the referral source must be provide the teen's name, date of birth, parent's name, contact information and county of residence. Information that is not known at the point of referral can be completed during the initial contact with the family.
- CHF staff complete the "For CHF Use" box, by entering the name of the CHF representative accepting the referral, the referral date, the name of the assigned RA, and the assignment date.
- In Part II, enter the date of eligibility determination and the check box indicating whether or not the teen is eligible. Check the criteria of eligibility and specify the "documented citizen" area. At least one CHF staff member must sign this form for eligibility determination. Additional CHF staff members may sign if they participated in the eligibility determination decision.
- File the form in the teen's Healthy Families Connection Program record.
- Disposition:** Healthy Families Connection Program records, including financial and automated information, must be maintained for a minimum of seven years following the teen's twenty-first birthday. Records must be archived in accordance with state requirements to ensure their preservation for the required length of time.

## HEALTHY FAMILIES CONNECTION- Referral Form

**Part I: IDENTIFYING INFORMATION**

Today's Date \_\_\_\_\_

1. Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

Male  Female Age: \_\_\_\_\_ Race: \_\_\_\_\_ County of Residence \_\_\_\_\_

Pregnant Due date: \_\_\_\_\_  Parenting No. of children: \_\_\_\_\_ Age of children: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Does teen have an IEP? \_\_\_\_\_

Other services the teen is connected with at school or elsewhere: \_\_\_\_\_

2. Parent/Legal Guardian Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

With whom does the teen live?  Both Parents  Father  Mother  FCCS Placement  Other: \_\_\_\_\_

Name if different from parents: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code County

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

**If the teen is in the legal custody of someone other than the person with whom he/she lives, complete the following:**

Name if different from parents: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code County

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

**REFERRAL SOURCE and CONCERNS**

1. Name of Person Making Referral: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check Agency/Office for which Referring Person Works:  Big Brothers Big Sisters  Ohio Health  IMPACT Columbus

Columbus City Schools: \_\_\_\_\_  Columbus Early Learning Center  The Columbus Urban League

The Center for Child and Family Advocacy  The Ohio State University – Access Program  Directions for Youth and Families

School: \_\_\_\_\_  Hospital/Doctor's Office: \_\_\_\_\_

Self: \_\_\_\_\_  Other: \_\_\_\_\_

2. Specific Concerns: \_\_\_\_\_  
 \_\_\_\_\_

3. If the referral is not from the parents, has the referral been discussed with the family?  Yes  No  N/A

If yes, when? \_\_\_\_\_ With whom? \_\_\_\_\_

## HEALTHY FAMILIES CONNECTION- Referral Form

**Part II: ADDITIONAL INFORMATION**

Today's Date \_\_\_\_\_

1. Primary Language of Parent: \_\_\_\_\_ Of Teen: \_\_\_\_\_

Interpreter Needed?  Yes  No If yes, for whom? \_\_\_\_\_ Translation needed?  Yes  No

2. Does the teen have a Service Coordinator/Case Manager?  Yes  No  Don't Know

If yes, indicate name and with what agency: \_\_\_\_\_

Special Instructions to the home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Person Completing Part 1: \_\_\_\_\_ \_\_\_\_\_  
(If other than CHF Staff) Date

**Part III: ELIGIBILITY DETERMINATION**

Criteria:  age 13-19  Franklin County Residence  Documented Citizen (specify document) \_\_\_\_\_

Yes  No (If no, specify): \_\_\_\_\_

Date of Eligibility Determination: \_\_\_\_\_

Signatures: (Signature of CHF staff member is required for eligibility determination)

\_\_\_\_\_ \_\_\_\_\_  
Date

\_\_\_\_\_ \_\_\_\_\_  
(additional CHF staff signature if applicable) Date

**For CHF Use**

Referral Date: \_\_\_\_\_ Name of CHF Representative Accepting Referral: \_\_\_\_\_

Orientation Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Name of RA and Date Assigned: \_\_\_\_\_