

HEALTHY FAMILIES CONNECTION- Referral Guide

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

Melanie Hill, Resource Advocate
614.884.4205 direct office/ 614.884.4201 fax
Melanie.Hill@centerforhealthyfamilies.org

- Purpose:** Completion of this form is required to document a referral to the Healthy Families Connection Collaborative.
- Instructions:** 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 provide the teen's name, date of birth, parent's name (if teen is under 18 years of age), contact information, county of residence, and specific reason for the referral. Other information that is not known at the point of referral can be completed during the initial contact with the family.
- 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.

Date referral received _____
 Date referral entered _____
 Date assigned to RA _____

HEALTHY FAMILIES CONNECTION- REFERRAL FORM

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: _____

2. Parent/Legal Guardian Name: _____

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: _____

If the teen lives with someone other than the person who has legal custody of him/her, please complete the following:

Name and relationship of who teen lives with: _____

Address: _____
Street City State Zip Code County

Home Phone Number: _____ Work Phone Number: _____ Cell Phone Number: _____

Referral Agency/Address _____ **Contact Number** _____

Specific Areas of Concern (REQUIRED) _____

ELIGIBILITY DETERMINATION

Criteria

age 13-19
 Franklin County Residence
 Documented Citizen (specify document) _____ Yes No (If no, specify): _____
 Date of Eligibility Determination: _____

REFERRAL INFORMATION

What are the primary concerns that brought the participant to Healthy Families Connections?

- Education
- Housing Safety/ Stability
- Parenting Skills
- Relationship concerns
- Employment
- Subsequent pregnancies
- Other: _____

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

Referral Representative Signature and Date: _____

HFC Staff Signature and Date: _____