



|                   |       |
|-------------------|-------|
| Participant Name: | _____ |
| Identification #: | _____ |
| Clinic #:         | _____ |

| Local HANDS Agency Information                |                     |
|---|---------------------|
| Agency Name: Hopkins County Health Department |                     |
| Contact Person: Brianna Gregory, LSW          |                     |
| Phone: (270) 821-5242 ex 240                  | Fax: (270) 825-0138 |
| Email: BriannaL.Gregory@ky.gov                |                     |

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<br><input type="checkbox"/> Community Based Services<br><input type="checkbox"/> Family Resource Center/School<br><input type="checkbox"/> Family/Neighbor/Friend<br><input type="checkbox"/> Head Start<br><input type="checkbox"/> Health Department<br><input type="checkbox"/> Hospital<br><input type="checkbox"/> OB/GYN<br><input type="checkbox"/> Other (List) _____<br><input type="checkbox"/> Physician<br><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.*   |  |                              |  |

