FSU Early Head Start
Referral Screening Form

Thank you for referring your families for Early Head Start Services. To process new applications efficiently, we ask that you please fill out the following information regarding the family you are assisting. Once the referral has been received, an Early Head Start staff member will contact the family to complete an application for services. If a child is found eligible but no slots are available at that time, they will be placed on a waiting list.

To be eligible for FSU Early Head Start services, families MUST:

- ❑ Reside in Gadsden County
- ❑ Be expecting a child or have a child under 3 years of age
- ❑ Provide a form of income verification* (TANF/SSI statement, recent pay stub, signed letter from employer, latest tax return, child support statement, statement of financial aid)

  or
- ❑ Children in foster care are automatically eligible (please provide documentation of foster care status)

*Families receiving TANF or SSI are automatically income eligible. Families without a "fixed, regular and adequate nighttime residence" are also automatically eligible under the McKinney-Vento federal definition of homelessness.

Families must provide proof of income during the time of application (see list above--SNAP food stamp and Medicaid eligibility statements do not count as income). Please inform the referred family that they will be required to discuss their income and housing situation and if it is consistent with your services, please assist them in collecting this documentation.

I am referring this family for home visiting services (weekly 90 minute home visits):

Parent/Guardian First Name: _____ M.I.: __ Last Name: _____

Child First Name: _____ M.I.: __ Last Name: _____ Child Date of Birth: _ _ /_ _ /_ _

Mother's Age: _____ Expectant Mother's Due Date (if applicable): _ _ / _ _ / _ _ _ _

Family Street Address: _____

City:_____ Zip Code: _____ Home Phone: _____ Other Phone: _____

Does this parent have any other children under 3 years old in the home? (List names if known)

_____

Special Concerns:

❑ Needs info on parenting ❑ Needs info on child development info ❑ First-time Parent ❑ Teen Parent
❑ Homeless ❑ Spanish speaking only ❑ Child has suspected/diagnosed developmental delay
❑ Domestic Violence ❑ Previous Miscarriage or poor birth outcome ❑ Other Special Needs:

If other: _____

Referring Agency: _____

Person Making Referral: _____ Title: _____
Contact Number: _____ Email: _____

Referring Agency Comments: _____

_____

_____

Other known services this person is involved with at the time of referral:
❑ DCF (❑Investigations ❑Case Management ❑Adoptions) ❑ Gadsden Woman to Woman ❑ Healthy Families ❑ Healthy Start ❑ WIC ❑ Early Steps ❑ Supplemental Security Income (SSI) ❑ TANF
❑ Medical Office ❑ Church ❑ Other:_____

Date Referral Made: _ _ /_ _ /_ _ _ _

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