Help Me Grow Washington

Help Me Grow Statewide Coordinated Access Point Standardized Referral Form

Process and Instructions

Please complete the referral form on behalf of your families. Once submitted, the information will be sent directly to Help Me Grow (HMG) via secure email or fax.

1. *HMG will reach out to the family within 48 hours of receiving the form according to the family's preferred contact method.*
2. *If you want be updated about the outcome of this referral, mark the box below.*

Please fax this referral form to Family Resource Navigator at: 360-365-8664
You can also call the Family Resource Navigator at 360-630-8352

In order for us to best meet this family's needs, please provide as much detail as possible:

FAMILY INFORMATION

Help Me Grow Washington provides social service linkages for adults and children living in Washington State. We prioritize households with children prenatal to 6 years of age.

***Is anyone in the household (Check all that apply):**
- ☐ Child under age 6
- ☐ Pregnant

***Zip code: __ __ __ __ __**

Total number of people in the household: _____

Estimated total household monthly income before taxes: $_____

What support is this family looking for?
- ☐ Early Learning & Child Development
- ☐ Items for pregnancy, baby, or family
- ☐ Parent/Caregiver Supports & Education
- ☐ Behavioral health & social emotional support
- ☐ Food Assistance
- ☐ Health Insurance Assistance & Resources
- ☐ Other: include information in notes
- ☐ Unsure (Help Me Grow will complete full needs assessment)

Any additional information that may help us make a connection

REFERRING PROVIDER INFORMATION

***Date of referral** MM/DD/YYYY

***Name of referring organization:**

_____

☐ I am a caregiver referring myself (skip the rest of this section)

Type of organization
- ☐ Hospital
- ☐ Clinic/clinical system
- ☐ Childcare/early learning
- ☐ Community Based Organization
- ☐ Other: _____

***Who should we contact for any follow up, and how may we reach you?**

Name: _____
- ☐ Phone:_____
- ☐ Email: _____
- ☐ Fax: _____

☐ **Check here if you want Help Me Grow to update you about the outcome of this referral**

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CHILD INFORMATION

☐ *Check if prenatal referral (skip the rest of this section)

***Child's Name:**
First: _____
Last: _____
***Child's DOB** MM/DD/YYYY

Child's race (check all that apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other
☐ Unknown

Child's ethnicity
☐ LatinX
☐ not LatinX
☐ Unknown

Child's gender
☐ Female
☐ Male
☐ Transgender male to female
☐ Transgender female to male
☐ Non-binary
☐ Prefer to self-describe:
_____
☐ Prefer not to share
☐ Unknown

CAREGIVER INFORMATION

***Caregiver Name**
First: _____
Last: _____

***Relationship to child**
☐ Parent
☐ Other family member
☐ Teacher
☐ Other: _____

***How may we contact the caregiver?**
☐ Phone:_____
☐ Email: _____
☐ Caregiver consents to text messaging

***Primary language spoken at home:**
☐ English
☐ Spanish
☐ Russian
☐ Vietnamese
☐ Other: _____

***Does caregiver want an interpreter? Specify language:**
☐ Yes: _____
☐ No

Caregiver's race (check all that apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Prefer to self-describe:
_____
☐ Unknown

Caregiver's ethnicity
☐ LatinX
☐ not LatinX
☐ Unknown

Caregiver's gender
☐ Female
☐ Male
☐ Transgender male to female
☐ Transgender female to male
☐ Non-binary
☐ Prefer to self-describe:
_____
☐ Prefer not to share
☐ Unknown

Caregiver's insurance status
☐ Medicaid
☐ Medicare/Classic Medicaid
☐ Private
☐ Uninsured
☐ Other: _____
☐ Unknown

Additional Children in Household

	Name	DOB	Check if seeking services
1		MM/DD/YYYY	☐
2		MM/DD/YYYY	☐
3		MM/DD/YYYY	☐
4		MM/DD/YYYY	☐
5		MM/DD/YYYY	☐

SPECIAL INSTRUCTIONS FOR EMERGENT SITUATIONS:
If you are concerned for your client and their family's safety, please call your county's crisis line or 911 for immediate support.