Healthy Families Day One

Child and Family Services of Northeast Michigan, Inc. Soon to be NORTHEAST MICHIGAN FAMILY RESOURCE CENTER

ALCONA/ ALPENA/ MONTMORENCY/ PRESQUE ISLE DAY ONE PROGRAM-REFERRAL FORM

Date:_____ Name of Referred:_____ DOB:_____

Address:_____ City:_____ County:_____

Phone:(Home)_____(Cell)_____(Other)_____

Email:_____ Emergency Contact: _____Number:_____

Now Pregnant?_____ EDC:_____

Name of Infant :_____DOB Infant:_____

Referring Agency:_____ Phone:_____

Name of Person Making Referral:_____

Weight in lbs.	Sex	Nursery Care	Multi-births	GA	Apgars

Risk Factors(Please check all that apply) _____Positive _____Negative

__ Single/no partner/separated/divorced __Unstable/dangerous living conditions __ Criminal history

__ Parent less than 18 years of age __ At Risk of poor bonding/attachment __ Substance Abuse

__ Lack of support system __ Late prenatal care/poor compliance __ Lack of parenting skills

__ No Transportation __ Consideration of adoption/abortion __ Education less than 12 years

__ Financial difficulties __ Limited intellectual abilities(parent) __ Considered adoption/abortion

__ History of CPS involvement __ Marital/family problems __ History of/current depression

__ Mother apathetic to instructions or keeping appointments __ Limited emotional abilities (parent) History of psychiatric care

Other Information:_____

If HFA Day One is unable to enroll the family due to lack of eligibility or program capacity, is the family open to additional community referral?

Please Circle YES or NO and Initial **Early Head Start** Yes No _____ **Head Start** Yes No _____

Baby Pantry Yes No _____ **MIHP** Yes No _____ **WIC** Yes No _____ **Early On** Yes No _____

Family declines additional referrals to be made Yes No _____

Parent Signature:_____Date:_____

Please send Form to: DAY ONE HFA KATIE ROUSSEAU Rousseauk@cfsnemi.org

Main Office: 1044 US 23 N. Alpena Phone: 989-356-4567 Ext: 208 Fax: 989-354-6100

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