LA COUNTY HOME VISITING PROGRAM
Confidential Referral Form

Revised Form (9/2020)
Please discard old forms

Phone: 1-800-427-8700 (press #4, option #2), 213-639-6478, Fax: 213-639-1035, OR Encrypted email to HomeVisit@ph.lacounty.gov

REFERRALS ACCEPTED FOR THOSE WHO MEET ANY OF THE FOLLOWING CRITERIA & AT LEAST ONE CIRCUMSTANCE BELOW:

☐ **Receiving CalWORKs AND/OR**

☐ **First-time** pregnancy **under 28 weeks** and **no previous live births.**

☐ Pregnant (not first pregnancy) and:
- ☐ Less than 28 Weeks, or
- ☐ Greater than 28 Weeks

☐ Parent, guardian, or caretaker relative of a **child less than 24 months old.**

☐ Parenting a child **less than 90 days postpartum.**

☐ Parent, guardian, or caregiver of **child/children up to 3 years old.**

OPTIONAL: HV Model preference, if eligible:
- ☐ Healthy Families America (HFA)
- ☐ Nurse-Family Partnership (NFP)
- ☐ Parents As Teachers (PAT)

Date: _____ **Person making referral:** _____ Title: _____

Agency Name: _____ Fax #: _____

Email Address: _____ Phone: _____ Cell Phone: _____

Name of Client: _____ Date of Birth: _____ Email Address: _____

If **pregnant**, Date of Delivery: _____ If **parenting**, DOB of Children: _____

If pregnant, is pregnancy confidential (to be kept privately from) to family/others? ☐ Yes ☐ No

Home Address: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Preferred Language: _____ Ethnicity: _____ Does client understand English? ☐ Yes ☐ No

Receiving Medi-Cal (MC): ☐ Yes ☐ No MC# _____ If no, is client Medi-Cal eligible? ☐ Yes ☐ No

Circumstances: (Current OR History Of – Please Check ALL that apply)

☐ Mental health condition/diagnosis	☐ Medical diagnosis/complexity	☐ 19 years old or younger
☐ Maternal depression/anxiety	☐ Housing issue, i.e. unstable housing	☐ Foster care system
☐ Involvement with DCFS	☐ Exposed to trauma/violence	☐ Stressed Family
☐ Substance use	☐ Less than HS education or GED	☐ No Support System
☐ Entry into juvenile justice system	☐ Previous pre-term birth (Less than 37 weeks)	
☐ Entry into criminal justice system	☐ Previous low birthweight baby (Less than 5lb, 8oz)	
☐ Adult and/or children with special needs: Pls. Specify: _____	☐ Unsafe physical living conditions: Pls. Specify: _____	☐ Other: _____

Authorization of Release: I give permission for representatives from LA County Department of Public Health (LAC DPH) Division of Maternal, Child and Adolescent Health (MCAH) and its contracted home visiting agencies to contact me regarding enrollment into one of its home visiting programs. I further understand that LAC DPH has authorized its contracted home visiting agencies to contract data administrators to provide technical support to the home visiting programs. The authorized data administrators may use my information listed on this form solely for the purpose of providing support and/or quality assurance. Additionally, if I potentially qualify for the Department of Public Social Services CalWORKs Home Visiting Program (HVP), my CalWORKs and Greater Avenue to Independence (GAIN) participation information may be viewed by LAC DPH HVP personnel to determine eligibility for HVP enrollment.

Client consented to be referred to home visiting programs. Signature: _____ or ☐ Verbal

Comments: _____

Clear Form