

## Help Me Grow Central WA Statewide Referral Form-Instructions and Process

Please complete the referral form on behalf of your families after receiving consent to share their information. The completed form can be sent via secure email or faxed. In order for us to best meet this family's needs, please provide as much detail as possible. Required information is marked with an asterisk (\*).

a. HMG will reach out to the family within 48 **business** hours of receiving the form according to the family's preferred contact method.

b. Please contact Help Me Grow Central WA Family Resource Navigator at [carinag@withinreachwa.org](mailto:carinag@withinreachwa.org) if you'd like technical assistance like a presentation on Help Me Grow or support with implementing the referral form at your site.

Please fax this referral form to: 509-490-3009 You can also call the Help Me Grow Hotline at 509-673-8446

Has the parent or caregiver agreed to have their contact and any demographic information shared with WithinReach for Help Me Grow Washington services?

Referring Provider Information	
<p><b>*Date of referral</b> __/__/____</p> <p><b>*Name of referring organization:</b> _____</p> <p><b>*Name of referring provider</b> _____</p> <p><b>Type of organization</b></p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Clinic/clinical system</p> <p><input type="checkbox"/> Childcare/early learning</p> <p><input type="checkbox"/> Community Based Organization</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>*Who should we contact for any follow up, and how may we reach you?</b></p> <p>Name: _____</p> <p>Phone: _____</p> <p>Email: _____</p> <p>Fax: _____</p>
Family Information (Child and Caregiver)	
<p><i>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.</i></p> <p><b>*Is anyone in the household (Check all that apply):</b></p> <p><input type="checkbox"/> Child under age 6</p> <p><input type="checkbox"/> Pregnant</p>	<p><b>*Zip code:</b> _____</p> <p><b>Total number of people in the household:</b> _____</p> <p><b>Estimated total household monthly income before taxes:</b> \$ _____</p>
<p><b>What support is this family looking for?</b></p> <p><input type="checkbox"/> Early Learning &amp; Child development</p> <p><input type="checkbox"/> Items for pregnancy, baby, or family</p> <p><input type="checkbox"/> Parent/Caregiver Supports &amp; Education</p> <p><input type="checkbox"/> Behavioral health &amp; social emotional support</p> <p><input type="checkbox"/> Food Assistance</p> <p><input type="checkbox"/> Health Insurance Assistance &amp; Resources</p> <p><input type="checkbox"/> Other: include information in notes</p> <p><input type="checkbox"/> Unsure (Help Me Grow will complete full needs assessment)</p> <p><b>Any additional information that may help us make a connection:</b></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	
<p><b>SPECIAL INSTRUCTIONS FOR EMERGENT SITUATIONS:</b> <i>If you are concerned for your client and their family's safety, please call your county's crisis line or 911 for immediate support.</i></p>	

CHILD INFORMATION	CAREGIVER INFORMATION																									
<p><input type="checkbox"/> *Check if prenatal referral (skip the rest of this section)</p> <p><b>*Child's Name:</b>            First: _____            Last: _____</p> <p><b>*Child's DOB</b> <input type="text" value="MM/DD/YYYY"/></p> <p><b>Child's race (check all that apply)</b>  <input type="checkbox"/> American Indian/Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Native Hawaiian/Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Other  <input type="checkbox"/> Unknown</p> <p><b>Child's ethnicity</b>  <input type="checkbox"/> LatinX  <input type="checkbox"/> not LatinX  <input type="checkbox"/> Unknown</p> <p><b>Child's gender</b>  <input type="checkbox"/> Female  <input type="checkbox"/> Male  <input type="checkbox"/> Transgender male to female  <input type="checkbox"/> Transgender female to male  <input type="checkbox"/> Non-binary  <input type="checkbox"/> Prefer to self-describe: _____  <input type="checkbox"/> Prefer not to share  <input type="checkbox"/> Unknown</p>	<p><b>*Caregiver Name</b>            First: _____            Last: _____</p> <p><b>*Relationship to child</b>  <input type="checkbox"/> Parent  <input type="checkbox"/> Other family member  <input type="checkbox"/> Teacher  <input type="checkbox"/> Other: _____</p> <p><b>*How may we contact the caregiver?</b>  <input type="checkbox"/> Phone: _____  <input type="checkbox"/> Email: _____  <input type="checkbox"/> Caregiver consents to text messaging</p> <p><b>*Primary language spoken at home:</b>  <input type="checkbox"/> English  <input type="checkbox"/> Spanish  <input type="checkbox"/> Russian  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Other: _____</p> <p><b>*Does caregiver want an interpreter?</b>  <b>Specify language:</b>  <input type="checkbox"/> Yes: _____  <input type="checkbox"/> No</p>		<p><b>Caregiver's race (check all that apply)</b>  <input type="checkbox"/> American Indian/Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Native Hawaiian/Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Prefer to self-describe: _____  <input type="checkbox"/> Unknown</p> <p><b>Caregiver's ethnicity</b>  <input type="checkbox"/> LatinX  <input type="checkbox"/> not LatinX  <input type="checkbox"/> Unknown</p> <p><b>Caregiver's gender</b>  <input type="checkbox"/> Female  <input type="checkbox"/> Male  <input type="checkbox"/> Transgender male to female  <input type="checkbox"/> Transgender female to male  <input type="checkbox"/> Non-binary  <input type="checkbox"/> Prefer to self-describe: _____  <input type="checkbox"/> Prefer not to share  <input type="checkbox"/> Unknown</p> <p><b>Caregiver's insurance status</b>  <input type="checkbox"/> Medicaid  <input type="checkbox"/> Medicare/Classic Medicaid  <input type="checkbox"/> Private  <input type="checkbox"/> Uninsured  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Unknown</p>																							
<p><b>Additional Children in Household</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;"></th> <th style="width:30%;">Name</th> <th style="width:20%;">DOB</th> <th style="width:45%;">Check if seeking services</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td><input type="text" value="MM/DD/YYYY"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>2</td> <td></td> <td><input type="text" value="MM/DD/YYYY"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3</td> <td></td> <td><input type="text" value="MM/DD/YYYY"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4</td> <td></td> <td><input type="text" value="MM/DD/YYYY"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5</td> <td></td> <td><input type="text" value="MM/DD/YYYY"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>				Name	DOB	Check if seeking services	1		<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/>	2		<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/>	3		<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/>	4		<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/>	5		<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/>
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