

**COMMUNITY RESOURCE AND REFERRAL FORM**

**(Primary Care Providers)**

*This form enables primary care providers to refer families to early intervention and early childhood special education*

*Including other community services/resources (via Help Me Grow/2-1-1) after a developmental screen is administered****.***

***Please complete the form on the second page.***

**USE THIS GUIDE AFTER A PEDS SCREEN:**

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| **AGE OF CHILD** | **HIGH RISK** | **MODERATE RISK** |
| ***Instructions:* *Please check the box below that best fits and fax to resource.*** | PEDS Path A, or M-CHAT failed or 3+ unmet milestones on the PEDS:DM | PEDS Path B or C, M-CHAT pass and <3unmet milestones on the PEDS:DM |
| [ ]  **Birth to 3 years** | **Child Development Watch (North)**Call #: (302) 283-7140Fax# 302-283-7142 | **2-1-1/Help Me Grow** Fax #: (302) 482-4462 |
| [ ]  **Birth to 3 years**

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 | **Child Development Watch (South)**Call #: (302) 424-7300Fax# 302-422-1363/302-424-2916 | **2-1-1/Help Me Grow** Fax #: (302) 482-4462 |
| [ ]  **3 to 8 years** | **Child Find** (See List below) | **2-1-1/Help Me Grow**Fax #: (302) 482-4462 |

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| **SCHOOL DISTRICT** | **NAME OF COORDINATOR** | **PHONE/FAX** | **EMAIL** |
| **Appoquinimink** | Kathy Gerstley | 302-376-4404/378-5696 | Kathy.gerstley@appo.k12.de.us |
| **Brandywine** | Joan McNamara | 302-479-2600/479-2216 | Joan.mcnamara@bsd.k12.de.us |
| **Caesar Rodney** | Brook CastilloAdrielle Benini  | 302-335-5039/335-3705 | Brook.castillo@cr.k12.de.usAdrielle.benini@cr.k12.de.us |
| **Cape Henlopen** | Susan Berry | 302-645-7210 | Susan.berry@cape.k12.de.us |
| **Capital** | Pam Nichols | 302-857-4241/672-1937 | Pamela.nichols@capital.k12.de.us |
| **Christina** | Dr. Amber SheltonDebra Norton | 302-454-2047302-454-2047 x2 | Amber.shelton@Chiristina.k12.de.usDebra.norton@christina.k12.de.us |
| **Colonial** | Tammy Wales | 302-429-4088/429-4097 | Tamara.wales@colonial.k12.de.us |
| **Delaware Early Childhood Center** | Dr. Tanya RobinsonTammy Brice | 302-398-8945 x101302-398-8945 x131 | tmrobinson@lf.k12.de.ustammy.brice@lf.k12.de.us |
| **Delmar** | Christina Fishburn | 302-846-9544/846-2793 | Christina.fishburn@delmar.k12.de.us |
| **Indian River** | Loretta Ewell | 302-732-1343/732-1344 | Loretta.ewell@IRSD.k12.de.us |
| **Lake Forest** | Dawn Troyer | 302-284-9611 x123 | dltroyer@lf.k12.de.us |
| **Laurel** | Zachary Furbay | 443-523-0699 | Zachary.furbay@laurel.k12.de.us |
| **Milford** | Anne Kneipp | 302-424-5474 | akneipp@msd.k12.de.us |
| **Red Clay** | Tina Albanese | 302-892-3227 | Tina.albanese@redclay.k12.de.us |
| **Seaford** | Lisa Doyle | 302-629-4587 x2054 | Lisa.doyle@seaford.k12.de.us |
| **Smyrna** | Carissa Stevens | 302-659-6287/653-3146 | Carissa.stevens@smyrna.k12.de.us |
| **Woodbridge** | Mondaria Batchelor |  | Mondaria.batchelor@wsd.k12.de.us |
| **Dept of ED (State Coordinator)** | Cindy Brown | 302-735-4295 | Cindy.brown@doe.k12.de.us |

**USE THE INFORMATION BELOW TO REFER TO A CHILD FIND PROGRAM:**

 Are the parents aware you are making a referral?

This form enables the provider to refer families to the FF :

**Child Development Watch**

**Child Find**

**Help Me Grow/2-1-1**

 How did you hear about the program? ­

**DATE:**

|  |  |  |
| --- | --- | --- |
| Child’s Name: First       Last       | Birthdate:        | Medicaid/DHSS Cares#        |
| Child’s Address:       (required)  | City/State/Zip        | Home Phone #:       (required) |

County:      Sex: [ ] Male [ ]  Female Child’s Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Child’s Race (CHECK ALL THAT APPLY): [ ] White [ ] Black or African American [ ] Asian [ ] American Indian or Alaska Native

 [ ] Native Hawaiian or Other Pacific Islander

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| School District       | Primary Language       |
| Mother’s Name       (required) MCI#       | Birth Date       Email        |
| Address       | Phone #(H)       (CELL)       (W)       |
| Father’s Name       MCI#       | Birth Date       Email        |
| Address (if different than client’s)       | Phone #(H)       (CELL)       (W)       |

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| *Guardian/Foster Parent/Educational Surrogate Name*  |
| *Address* *Phone #(H)       (CELL)       (W)* |
|  |
| Birth Weight       Current Weight       | Gestation (weeks)       APGARS       |
| PCP/Office       | Phone #       Fax #       |
| ICD10                               |  |
|  |  |
| Insurance Information |
| Private Insurance Co. Name:      Policy Holder: [ ] Mom [ ] Dad *(MUST include DOB above)*Group/Acct #       Member ID#      Effective Date:      Address:       Phone #        | *IF DELAWARE MEDICAID ONLY - CHECK BELOW:* *[ ] MA-Fee For Service/traditional* *[ ] MA-Highmark Health Options* *[ ] MA-United Healthcare**Notes:*       |

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| Child Care Name       Address       Phone#        |
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| ***REFERRING AGENCY/PERSON***       Phone #       Email:       |
| [ ]  PEDS Screener [ ]  ASQ [ ]  MCHAT [ ]  Other screening (please specify):       |

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| ***RECEIVING AGENCY ACTION***       | ***DATE***       |

**Reason for referral:**