Maternal and Child Health Consortium

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# MCHC PROGRAMS REFERRAL

**Coatesville/Kennett Square/Oxford/Phoenixville/Pottstown/West Chester**

## HEALTHY START – FAMILY BENEFITS – FAMILY CENTER

**Date:** _____

**Referral Source**

Name: _____Agency/Org:_____Telephone:_____

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**General Client Information**

Name: _____Telephone (s):_____ AGE:___ DOB:___ /___/____

Address:_____ , City:_____ , PA Zip Code:_____

Race:_____ Ethnicity:_____
(Black, African American, Caucasian, Asian, Biracial, Pacific Islander) (Hispanic / non-Hispanic)

Primary Language: _____

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**HEALTHY START (home visiting program for pregnant women / mother of child less than 1 month old and mothers with high needs)**

EDD: ___/___ /___ Baby's DOB:___ /___ /___ Prenatal/Pediatric Care Provider:_____

First pregnancy? Yes___ No ___ First pregnancy in the United States? Yes___ No __

Has participant agreed to have us contact her? Yes ___No ___ Not aware of referral ____

Is household aware of pregnancy? Yes___ No ___

- o Needs Prenatal Care? Yes ___ No ____
- o Needs Dental Care? Yes ___ No ___
- o Needs Health Insurance? Yes ___ No ___
- o Need Food Stamps? Yes ___No ___
- o Needs to enroll in the WIC Program? Yes ___ No ___
- o Other: _____

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**FAMILY BENEFITS (assistance to apply for benefits for themselves or for any family member)**

- o Needs Health Insurance? Yes ___ No ___
- o Need Food Stamps? Yes ___ No ___
- o Cash Assistance? Yes __ No ___
- o Other: _____

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**FAMILY CENTER (Kennett Square/Oxford, home visiting program for parents of children ages 0 to 5)**

Age of Child: _____

Child's DOB: ____/____/____

Number of children in household under 5 years old:_____