The Children's Home Society OF NEW JERSEY®

Central Intake
Monmouth and Ocean County
Initial Referral Form

PLEASE PRINT CLEARLY

* REQUIRED *

*Date of Referral ___ - ___ - ___

Participant Information

*Last Name _____ *First Name _____ *Date of Birth ___ - ___ - ___

*Street Address _____ *City _____

*Zip Code _____ *County _____ Participant ID _____

***Primary Language** *(Choose one)*
- ○ English
- ○ Spanish
- ○ Other _____

***Race** *(Choose one)*
- ○ Black
- ○ White
- ○ Asian
- ○ Native American
- ○ Multi-Racial
- ○ Alaskan/Pacific Islander
- ○ Other _____

***Ethnicity** Hispanic ○ Yes ○ No

***Health Insurance** *(Select all that apply)*
- ○ Medicaid PE
- ○ Medicaid MC
- ○ NJ Family Care
- ○ Medicare
- ○ Commercial/Private
- ○ Uninsured/Self Pay

Participant Contact Information

*Primary Phone ___ - ___ - ___

Alternate Phone ___ - ___ - ___

Email Address _____

***Preferred Contact Method** *(Choose one)*
- ○ Primary Phone
- ○ Alternate Phone
- ○ Email
- ○ Text

***At which phone number can we text you?**
- ○ Primary
- ○ Alternate
- ○ None

Household Information

Married? ○ Yes ○ No

* # of Children in the home ___

Date(s) of birth of children needing services	Name of Child	Relationship
1. ___/___/___		
2. ___/___/___		
3. ___/___/___		

Participant Is... *(Choose One)*

○ Preconceptional Woman	○ Pregnant Woman	○ Interconceptional Woman	○ Male
Has no children and has never been pregnant.	***First Time Parent?** ○ Yes ○ No ***In Prenatal Care?** ○ Yes ○ No ***Due Date** ___ - ___ - ___	*Previously pregnant and not currently pregnant. (Does not matter if woman has children.)* ***First Time Parent?** ○ Yes ○ No	***Are you a Parent?** ○ Yes ○ No ***First Time Parent?** ○ Yes ○ No **Does your child live w/ you?** ○ Yes ○ No

Reason for Referral - Household Needs

- ___ Primary care for myself
- ___ Primary care for my children
- ___ Prenatal care
- ___ Public benefits
- ___ In-home parent support (home visiting)
- ___ Assistance connecting to services (CHW)
- ___ Group parent support
- ___ Recovery Support Services
- ___ Other _____

Referral Agency Information

*Referral Agency Name _____

Name of Person Making the Referral _____ Phone ___ - ___ - ___

Email Address _____ Phone Extension _____

Comments

Program Use Only

Date Pregnancy Test Given ___ - ___ - ___

Pregnancy Test Positive? ○ Yes ○ No

Outreach Type
- ○ Agency
- ○ Door to Door
- ○ Self
- ○ Event *(Specify)* _____

* Participant Consent

I agree to have the information I provided for this initial referral shared with the Central Intake hub for my county. I agree to be contacted by Central Intake staff, who will further assist with connecting me and/or my family to supportive services.

○ Oral consent given

Signature of Participant

Sign _____ *Print* _____

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Tel: 1 877-352-7843 Fax# **(732) 475-7734**

CIMO@chsofnj.org