Healthy Starts Program Referral Form

24/7 Referrals: 1-800-541-4145 Fax to 603-357-2545

Referral Source: **Date:**

Referral Contact: **Phone:**

PARENT(S)

Parent/Guardian Name:	**Parent/Guardian Name**:
DOB:	DOB:
Address:	Address:
Town:	Town:
Zip:	Zip:
Phone: (H) (C)	Phone: (H) (C)
Is it ok to leave a message? Yes	Is it ok to leave a message? Yes
Physician:	
If pregnant, due date:	
Medicaid ID#	Medicaid ID #

CHILDREN

CHILDREN OR OTHERS LIVING IN THE HOUSEHOLD

First Name:	Last Name:	DOB:
Relationship:	Medicaid ID#:	
First Name:	Last Name:	DOB:
Relationship:	Medicaid ID#:	
First Name:	Last Name:	DOB:
Relationship:	Medicaid ID#:	

Any other agency involvement? Yes If yes, who?

Reason for referral (family challenges and strengths):

Release/Consent on page 2

Please read and complete before signing this form:

The information on this form is true and complete to the best of my knowledge. I agree to allow an exchange of information between this agency, , and HCS' Healthy Starts Program to ensure that I am offered supports and services. I understand that information disclosed is protected by Federal Regulation 42 CFR Part 2 and 45 CFR Part 164. It cannot be released without my consent unless otherwise required by law. Disclosure of this information without my consent by the receiving party is pro-hibited. I understand that I need not consent to the disclosure of information in order to obtain services except in instances that are under court order. I choose to disclose this information willingly and voluntarily for the purposes specified above. I also understand that I may revoke this consent at any time by notification in writing to above names parties.

Parent/Guardian signature Printed name Date

HCS No. 496 4/15/2022