



SCAN/EMAIL COMPLETED REFERRAL TO [tllongo@howardcountymd.gov](mailto:tllongo@howardcountymd.gov). Please do not fax.

**Referral Form for Cribs for Kids® Program and Car Seat Assistance Program**

❖ CHECK WHICH PROGRAM (S) FAMILY IS BEING REFERRED TO:

Cribs for Kids® Program (no fee): \_\_\_\_ Car Seat Assistance Program (\$40 fee) \_\_\_\_

**For completion by Referring Staff Member:**

Date of Referral: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Staff Name, Phone #, & Email: \_\_\_\_\_

Need of Client (brief description of family circumstances to support need): \_\_\_\_\_

**Recipient information:**

Name of Mother/Guardian: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Race: Asian \_\_\_\_ Black \_\_\_\_ White \_\_\_\_ Other \_\_\_\_ Preferred Language: \_\_\_\_\_

Ethnicity: Hispanic \_\_\_\_ Non-Hispanic \_\_\_\_

Baby's Due Date: \_\_\_\_\_ OR Baby's DOB: \_\_\_\_\_ Baby's Estimated Weight: \_\_\_\_\_

Baby's Estimated Height: \_\_\_\_\_

**For completion by Program Coordinator:**

Date of phone contact with recipient: \_\_\_\_\_ Appointment date/time: \_\_\_\_\_

\_\_\_\_\_ Rescheduled Appointment date/time: \_\_\_\_\_

\_\_\_\_\_ Rescheduled Appointment date/time: \_\_\_\_\_

Date confirmation was letter sent: \_\_\_\_\_

**Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Questions? Contact Program Coordinator, Tricia Longo, at [tllongo@howardcountymd.gov](mailto:tllongo@howardcountymd.gov) or 410-313-6109