



SCAN/EMAIL COMPLETED REFERRAL TO 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 Contact 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 #:** _____

Race: Asian ___ Black ___ White ___ Other _____ **Preferred Language:** _____

Ethnicity: Hispanic ___ Non-Hispanic ___

Baby's Due Date: _____ **OR Baby's DOB:** _____

Baby's Estimated Height: _____ **Baby's Estimated Weight:** _____

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 or 410-313-6109