CRIBS FOR KIDS® INTAKE/REFERRAL APPLICATION

Criteria

Parent(s) or Caregiver(s) must be able to provide one copy of the following documents from each section to be considered for approval. A) Identification; Florida driver's licenses or Identification card with Broward County address, Broward County School ID or Broward County School Demographics Record, Social Security Card, Green Card, or Passport. **Note**: If passport has not been issued by the United States, or the participant can not provide above documentation due to being an undocumented resident, a Broward County bill must be attached to application, or the application will be declined. **Please do not send bank statements, credit card statements, or rent lease agreements, these items will not satisfy this criterion.** B) Proof of Need: Medicaid number documentation, WIC number documentation, A patient authorized released hospital face sheet stating Medicaid number information , Recent Pay Stub that meets 185% of the Florida Poverty guidelines (to be determined by Cribs staff), Unemployment documentation, SSI document, SSA document, Food stamp letter, notarized letter of support from employer or person supporting the participant. If a copy of Medicaid or WIC information cannot be provided, a case manager or referring agency person must write down the Medicaid or WIC number along with their signature. **Mother must be at least 30 weeks pregnant to be referred to the program. Mother must be at least 36 weeks pregnant, or have a premature infant to receive a crib.**
Fulfillment of Criteria must be met, or application will postponed and may be declined.

From (*person making the referral*) ___________________________ Title___________________________

Referring Agency ____

Agency's Address____

Phone Number (   ) ___________________________ Fax (   ) ______________________________

Recipient's Demographic Information:

Mother's First Name ____________________________ Last Name ___________________________

Father's First Name ____________________________ Last Name ___________________________
(Father's Information is optional)

Child's First Name _____________________________Last Name_____________________________

Child's First Name_____________________________ (Use for multi-gestation only)

Child's First Name _____________________________ (Use for multi-gestation only)

Gender: ☐Female ☐Male Prenatal Care: Yes ☐ No☐ Multi-gestation (please specify) Twins ☐ Triplets ☐

MOB SSN: _________________________

Mother's DOB _____/____/_____ **Father's DOB** _____/_____/_____

Child's DOB: ____/____/____ or **Child's Due Date:**____/____/____ (**MOB must be 30 weeks or more to refer to program**)

Baby's weight: _________________________ **(required if baby is 6 months or older)**

Address: ____ Apt: ___________

City/State: ____ Zip Code: ______________________

Phone Number#:____________________________ Emergency contact #: _________________________
Emergency Contact Name______________________

Race: ☐Black ☐White☐ Multi/Bi-Racial, ☐Asian or Pacific ☐Native American ☐ Other ____________

Ethnicity (please specify): ________________________ **Language spoken**: ___________________________

MOB ☐ Single ☐ Married ☐ Separated

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Finances/ Proof of Need **(Mandatory)**

MOB Employed ☐ Yes ☐ No FOB **Employed** ☐ Yes ☐ No **Household Monthly Income:** _______

MOB Receives the Following: ☐ WIC ☐ Medicaid ☐ Food Stamps ☐ Cash Assistance

☐ **Other**: ______________________________ **How are bills being paid:** _______________________

Medicaid #: ________________________ **WIC#:**______________________________________

Comments____

CM/Referring Agency Referrer Signature: ____

Household Members **(How many of the following):**

Adults in home: ______ Children in home: ______ Rooms in home: ______

Sleeping Arrangement

Where is child currently sleeping? ☐ Co-Sleeping ☐ Bassinet
☐ NICU ☐ Other (Specify) ____

Where were you planning on having child sleep? ☐ Crib ☐ Other (Specify______________________

Community Resources **(self referral only)**
Have you tried any other resources in the community? ☐ Yes ☐ No

Are you enrolled in a community program? ☐ Yes ☐ No
If yes, Program: ______________________________________ ☐ Unknown

Case manager's Name: _________________________________ ☐ Unknown

Resources Provided: ☐ None Provided ☐ Respect for Life ☐Hope Pregnancy ☐ Sheppard's Way ☐ First Care

☐ Other________________________________

Comments:____
____
____

Participant's Signature: ____**Date** _________________
(Consent may be verbal)
Referring agency person's/CM's Signature: ___________________________ **Date** ___________________

Healthy Mothers, Healthy Babies Coalition of Broward County, Inc
P.O. Box 350446, Fort Lauderdale, FL 33315
Phone 954-765-0550 ▪ Fax 954-765-0587

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