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. Section A) Proof Broward Residency: Identification; Florida driver's licenses or Identification card with Broward County address, Broward County School ID or Broward County School Demographics Record, 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. Section B)** Proof of Income: Recent Pay Stub that meets 180% of the Florida Poverty guidelines (to be determined by crib's staff), documentation showing the approval amount for unemployment, cash assistances, SSI, SSA , letter of support from employer, homeless shelter, or person supporting the participant. **Section C) Proof of Need:** Medicaid number identification documentation, WIC identification number documentation, Hospital (A patient authorized released hospital face sheet stating Medicaid number information), and Letter stating food stamp approval 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 (   ) ______________________ Email ______________________

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______________________

2nd Child's First Name______________________ 3rd Child's First Name ______________________

(Use for multi-gestation only)

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

MOB SSN: ____________________ **MOB Email:** ____________________

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: FL Zip Code: ____________________

Phone Number#:______________________ Emergency contact Name/Number: ______________________

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Healthy Mothers, Healthy Babies
Coalition of Broward County, Inc.
Nurturing Mothers, Babies

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

Ethnicity (please specify): ______________________ **Language spoken**: ________________________________

MOB ☐ Single ☐ Living with a partner ☐ Married ☐ Separated ☐ Divorced

Finances/ Proof of Income & Proof of Need (Mandatory)

MOB Employed ☐ Yes ☐ Not Employed **FOB Employed** ☐ Yes ☐ Not Employed

Household Monthly Income: ______________________________ **(Must specify amount & Proof Required See Criteria)**

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

☐ **Other**: ________________________________ **How are the bills being paid:** ___________________________

Medicaid #: __________________________ **WIC#:**____

Comments____

Household Members (How many of the following):

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

Sleeping Arrangement

Where is child currently sleeping? ☐ Prenatal ☐ 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** __________________
(Signature Required)

Healthy Mothers, Healthy Babies Coalition of Broward County, Inc
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