Referral/Request for Healthier Beginnings/PAFT Service

EBHV (Home Visiting) service for families prenatal to child's kindergarten entry

Hamilton County Health Department
921 East Third Street, Chattanooga, TN 37403
Telephone: 423-209-8298 / **FAX**: 423-209-8178
Email: jaimeed@hamiltontn.gov

Date Referred:
Parent/Guardian Name: **DOB:** **SS#:**
Address:
Phone: **Cell:** **Emergency Contact:**

Children/Prenatal	Date of Birth/Due Date	Child's SS #

Family Characteristics: Check all appropriate for this family (must have at least one of these characteristics).

#	√	Characteristic	#	√	Characteristic
1.		Low Income Family	5.		Child has developmental delays or disabilities
2.		Pregnant woman or new mother/under age 21	6.		Have children with low student achievement
3.		Are users of tobacco products in the home	7.		Parent/caregiver history of or suspected current substance abuse
4.		Parent/caregiver history of/ current/suspected child abuse or neglect, or have had interaction with child welfare services	8.		Family members are or have served in the armed forces with multiple deployments outside the U.S.

Additional Information/Concerns: _____

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Referral/Request Source

Agency/Organization or Self:
Representative: **Telephone**:
Representative's e-mail: **Agency Fax #:**

FOR PAFT USE ONLY

Date referral received by PAFT:	NOTES
Date assigned to Parent Educator:	1st Contact:
Parent Educator assigned:	2nd Contact:
☐ Enrolled	3rd Contact:
☐ Wait List	Notes:
☐ Closed – Reason:	