Web referral form: helpmegrow.org
Fax: (855) 418-3322 or (855) 318-3322

Department of Children & Youth
Help Me Grow

Phone: (800) 755-GROW (4769)
Email: HMGreferrals@helpmegrow.org

CAREGIVER INFORMATION

*Primary Caregiver first name _____ *Primary Caregiver last name _____

*Primary Caregiver relationship to child ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Stepmother ☐ Stepfather ☐ Adoptive mother ☐ Adoptive father ☐ Foster parent (female) ☐ Foster parent (male) ☐ Kinship/other (female) ☐ Kinship/other (male)

**At least one contact method is required (email, phone, or address) Email _____

Phone ( )_____-_____ Address _____ City _____ Zip _____

County _____ Best time to contact ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

Preferred contact method ☐ Phone ☐ Text ☐ In person ☐ Letter ☐ Email ☐ Fax

*Primary language spoke in the home _____ Interpreter required? ☐ Yes ☐ No

ADDITIONAL CAREGIVER/ALTERNATE CONTACT

First name _____ Last name _____

Relationship to primary caregiver _____ Phone ( )_____-_____

CHILD(REN) INFORMATION

*Primary caregiver is currently pregnant ☐ Yes ☐ No

If yes, *Due Date: _____/_____/_____

*Date of Birth _____/_____/_____
*First name _____
*Last name _____
Gender _____
Child resides with _____
*Are there concerns about this child's development? ☐ Yes ☐ No
*Is there a diagnosed medical condition that could cause delay? ☐ Yes ☐ No
(Please explain below)

*Date of Birth _____/_____/_____
*First name _____
*Last name _____
Gender _____
Child resides with _____
*Are there concerns about this child's development? ☐ Yes ☐ No
*Is there a diagnosed medical condition that could cause delay? ☐ Yes ☐ No
(Please explain below)

INDICATE PROGRAM YOU ARE INTERESTED IN MAKING A REFERRAL TO:

☐ **ASQ Online:** Screening for birth through 5 to track developmental milestones.

☐ **Early Intervention:** For children under 3 with developmental delays or disabilities.

☐ **Family Connects:** Free newborn home visit from a registered nurse.

☐ **Home Visiting:** Family support for pregnant individuals or new parents.

ADDITIONAL INFORMATION - Please briefly tell us why you are seeking Help Me Grow support.

*WHO IS MAKING THE REFERRAL?

☐ I am making the referral for my family ☐ I am a Healthcare professional ☐ I am for a friend ☐ Other

First name _____ Last name _____

Agency/ Organization _____

**At least one contact method is required (email, phone, or address)

Email _____ Phone ( )_____-_____ Address _____

City _____ Zip _____ County _____

How did you hear about Help Me Grow? ☐ Advertisement ☐ Child care ☐ Caregiver ☐ Community Event ☐ Educator ☐ Family member ☐ Friend ☐ Local service agency ☐ Physician or other medical professional ☐ Website- Help Me Grow ☐ Website- Ohio Early Intervention ☐ Website- Other ☐ Other ☐ Prefer not to answer ☐ CI Initiated Contact ☐ Not sure ☐ Referred Prior to Release (temporary) ☐ Billboard ☐ Broadcast (TV/Radio) ☐ News Media Article/Show ☐ Public Sign