healthy families lake county
a program of MHA of Lake County

REFERRAL FORM

FAX FORM TO: 219.736.4998 or email to: info@mhalakecounty.org

PRIMARY PROGRAM ELIGIBILITY: PRENATAL OR BABY IS YOUNGER THAN 3 MONTHS OF AGE

To Be Completed by Referral Agency or Organization: **DATE: _____/_____/_____**

PARENT INFORMATION:

First and Last Name		**Age**	**Date of Birth (mm/dd/yyyy)**
Expected delivery date, if applicable	**Speaks English?** ☐ **Yes** ☐ **No**	**Preferred language:**	
Address		**Apt. #**	**City, State, Zip**
Primary Phone Number ☐ **Home** ☐ **Cell**		**Alternate Phone Number**	
Is parent receiving other services (WIC, Food Stamps, Medicaid, etc.) ☐ **Yes** ☐ **No**	**If yes, what services?**		

BABY INFORMATION, if applicable:

Baby Name	**Gender**	**Date of Birth**

Parent listed above **gives permission to be contacted by Healthy Families** staff in regards to program services that may be available to me and my family. I also give permission to provide my initial enrollment status back to the referring program.

Parent Signature: _____ Date: _____

Referral Agency: _____Contact Name: _____

Contact Email: _____Contact Phone:_____

OPTIONAL for referral agency:

☐ **I Want to be Faxed the Outcome of this Referral** **Agency Fax Number:** _____

☐ We were unable to contact family ☐ We made contact and family enrolled ☐ Family did not meet eligibility

☐ Family declined ☐ We referred to a more appropriate agency

HF Contact Name: _____ ☐ Crown Point office ☐ Hammond office