**Referral for the Young Parent Support Program**

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| **Eligibility:** | | **Pregnant  Parenting** | | | | | | | | | | | | | | **22 years old or younger?** | | | | | | | | |
| **Location:** | | **Lynn: 112 Market Street, Lynn; p: 774-270-0453**  **Please fax to: (781) 595-4393 or** [**hsalihin@jri.org**](mailto:hsalihin@jri.org)**, Hayfa Salihin ph# (978)560-7553** | | | | | | | | | | | | | | **Lowell: 227 Chelmsford Street, Suite C; p: 774-270-0453**  **Please email to:** [**Kmarquez@jri.org**](mailto:Kmarquez@jri.org) **Kistal Marquez** | | | | | | | | |
| **Young Parent Information:** | | | | | | | | | | | Preferred Language: English Spanish Other: | | | | | | | | | | |  | | |
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| **Name:** |  | | | | | | | | | | | | | | | | **D.O.B:** | | | | |  | | |
| **Address:** |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Home Telephone:** | | | | | |  | | | | | **Cell Phone:** | | |  | | | | | **Other Phone:** | | | |  | |
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| **Race:** | | | | American Indian or Alaskan Native  Asian  Black or African American  Hispanic, Latino, or Spanish Origin  Native Hawaiian or other Pacific Islander  White  Other Race: | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity:** | | | | Not Hispanic or Latino  Hispanic or Latino | | | | | | | | | | | | | | | | | | | | |
| **Gender:**  **Education:**  **Employment** | | | Male  Female  Other/Nonconforming  Transgender: Male to Female  Transgender: Female to Male  Currently in HS Program Completed High School GED HiSet Last grade completed: \_\_\_\_\_  In College  Yes: Full-Time Part-Time No Current Living Situation: | | | | | | | | | | | | | | | | | | | | | |
| **Child(ren) Information:** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | | **Date of Birth** | | | **Please note if any specific concerns or support needed** | | | | | | | | | |
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| **Reason for Referral/Specific Supports that would be Helpful** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Services Already in Place (check all that apply):** | | | | | | | | | | | | | | | | | | | | | | | | |
| TAFDC  Food Stamps  WIC  SSI  SSDI  MassHealth  Housing Assistance  DOR  Childcare  Early Intervention  Outpatient Services  In-Home Therapy  Community Service Agency  Other: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is DCF currently involved?**  No  Yes – Name and Tel # of Social Worker: | | | | | | | | | | | | | | | | | | | |  | | | | |
| **Referral Source Information:** | | | | | | | **Name:** | | |  | | | | | | | | | | **Date of Referral:** | | | |  |
| **Relationship to Young Adult:** | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Work Telephone:** | | | | |  | | | | **Cell Phone:** | | | |  | | | | | **e-mail:** | | |  | | | |
| **Any Safety Concerns? NO YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (any risks doing homevisits, transporting?** | | | | | | | | | | | | | | | | | | | | | | | | |
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