CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

Referral for the Young Parent Support Program

Eligibility: ☐ **Pregnant** ☐ **Parenting** ☐ **22 years old or younger?**

Location: ☐ **Lynn:** 112 Market Street, Lynn; p: 978-560-7553
Please email to: hsalihin@jri.org Hayfa Salihin

☐ **Lowell:** 227 Chelmsford Street, Suite C; p: 774-504-4334
Please email to: Kmarquez@jri.org Kristal Marquez

Young Parent Information:

Preferred Language: ☐English ☐Spanish ☐Other:

Name: _____ **D.O.B:** _____
Address: _____
Email Address: _____ **Cell Phone:** _____ **Other Phone:** _____

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: ☐ Male ☐ Female ☐ Other/Nonconforming ☐ Transgender: Male to Female ☐ Transgender: Female to Male
Education: ☐ Currently in HS Program ☐Completed High School ☐GED ☐HiSet ☐Last grade completed: _____ ☐ In College
Allergy: ☐ Yes ☐ No

Employment ☐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

Reason for Referral/Specific Supports that would be Helpful

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 home visits, transporting?**


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