healthy families
ONEIDA COUNTY
A program of ican

Referral Form

Today's Date: ____ / ____ / ____

Please fill out and email to: healthyfamilies@ican.family or fax to (315) 792-9578

Parent 1/Caregiver 1's Name: _____ DOB: ____ / ____ / ____ Phone #: _____

Street Address: _____City: _____ State: _____ Zip: _____

Email Address: _____

Parent 2/Caregiver 2's Name: _____ DOB: ____ / ____ / ____ Phone #: _____

Street Address: _____City: _____ State: _____ Zip: _____

Email Address: _____

Estimated Due Date or Date of Delivery: ____ / ____ / ____

How do you prefer to be contacted? (check all that apply) ❍ Text ❍ Phone Call ❍Email

Is it okay to leave voicemails on your phone? ❍ Yes ❍ No

1. Choose the one that best applies:

❍ Married ❍ In a Relationship/Unmarried ❍ Single ❍ Divorced/Separated ❍ Widowed

2. When did your prenatal care begin?

❍ 1-12 weeks ❍ 13-24 weeks ❍ 25-40 weeks ❍ No Prenatal Care

3. Which services do you currently receive?

❍ WIC ❍ SSI/SSD ❍ SNAP (formerly known as food stamps) ❍ HEAP ❍ Medicaid ❍ Public Assistance

❍ None ❍ Other: _____

4. Who can you count on for support?:

❍ Partner ❍ Parents ❍ Grandparents ❍ Other Family ❍ Friends ❍ No One

❍ Other: _____

❍ Please do not contact me (by checking this box you are stating that you do not want anyone from Healthy Families to contact you)

By signing, I understand that a representative from the Healthy Families Oneida County program will contact me with more information.

Signature: _____ Date: ____ / ____ / ____

Referral Information

Referral Source 's Name: _____Phone Number: _____

Referral/Recruitment Source (Check Only One)

❍ Private Physician ❍ Health Clinic ❍ Hospital ❍ WIC ❍ DSS/CPS ❍ Home Visiting Program ❍ Visiting Nurses