EightCAP, Inc. 0-5 Head Start

Referral Form

0-5

Today's Date:_____ County: _____

Parent/Guardian Name:_____ Birth Date:_____

Parent Address (include city and zip):_____

Phone: _____

Childs Name: _____ Birth Date: _____ Sex ☐ M ☐ F

Childs Name:_____ Birth Date: _____ Sex ☐ M ☐ F

Program(s) applying for: ☐ **Head Start** (ages 3-5) and/or
Early Head Start (prenatal moms and children ages 0-3) ☐ Home Based ☐ Center Based

Please list reasons family would benefit from EightCAP, Inc. 0-5 Early Childhood Programs:

(If Applicable, for Foster Care; otherwise go to next question):

Foster Parent Name: _____ Phone: _____

Foster Parent Address: _____

How long in foster care? _____ Would foster parents allow visits in home? ☐ Yes ☐ No

County visits take place: _____

Is the child or parent involved with:

☐ Mental Health Agency:_____
☐ Early On
☐ DHHS
☐ Other: _____

Check all that apply:

☐ Teenage parent (under 20) ☐ Foster Care

☐ Child or family with special needs ☐ Homeless

Case Worker: _____

Contact Number: _____

Email address: _____

Agency referring: _____

Please fax: 616-754-9310 or email to Denise at deniseb@8cap.org

6/20/23 JA,AB/DB ERSEA: ERSEA