CAP AGENCY
COMMUNITY ACTION PARTNERSHIP
OF SCOTT CARVER & DAKOTA COUNTIES

Head Start

www.capagency.org

738- 1st Avenue East
Shakopee, MN 55379
952-496-2125
952-402-9816 (fax)

2496 145th Street West
Rosemount, MN 55068
651-322-3500
651-322-3555 (fax)

Referral to CAP Agency Head Start 1302.41

Name of person referring_____ Date of Referral_____

Agency_____ City_____

Email Address_____ Phone _____

Check One: ☐ I've given Head Start application to family ☐ Please mail Head Start application to family

Referring Individual's Signature: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Address: _____

Email Address_____ Phone _____

1. What life events apply to this ***family***? Check all that apply. Family members include anyone living in the home.

- ☐ Chemical abuse in the home
- ☐ Physical abuse—current or in the past
- ☐ Verbal abuse—current or in the past
- ☐ Sexual abuse—current or in the past
- ☐ Death of a parent, brother, sister, other primary care-giver
- ☐ Jail sentence of family member
- ☐ Child has visible or congenital deformity
- ☐ Serious illness of family member
- ☐ Inadequate housing, homeless, hazardous housing
- ☐ Increase of chemical use by family member
- ☐ Developmentally challenged family member
- ☐ Parent or primary care-giver with mental illness
- ☐ Other household member (not parent) with mental illness
- ☐ Divorce and/or separation of parents
- ☐ One or both parents is totally absent from child's life
- ☐ Addition of step-parent to family
- ☐ Recent birth of sibling
- ☐ Parent beginning work or school
- ☐ Addition of unrelated adult to household
- ☐ Loss of job by a parent
- ☐ Change in parent's financial status
- ☐ Low-income with financial struggles
- ☐ Recent move to a new home
- ☐ Child has documented special needs
- ☐ Other (Please explain below)

***Give us as much information as possible to help us understand stress within the family that may interfere with this child's normal, healthy, growth and development. Use additional paper if necessary.

2. Do you have concerns about this *child's* development or behavior? Check all that apply.

- ☐ Social/Emotional Development or Mental Health
- ☐ Physical Development (Health, Nutrition, Growth, Balance, Sensory, Large Motor, Fine Motor etc)
- ☐ Speech or Language
- ☐ Cognitive Development
- ☐ Other

Explain _____

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3. Has the child received an Early Childhood screening completed by their school district? No / Yes
If yes, which school district completed the screening: _____
If yes, was the child referred for additional evaluations: No / Yes

4. Has this child been evaluated for special education services? No / Yes

If the child was evaluated, did the child qualify for special education? No / Yes*

**Diagnosis* _____ *District providing services_____

*Comments:*_____

5. Does this child have diagnosed health risks that may impact ability to learn or require school accommodations? No / Yes*

* *Explain*_____

_____

6. Additional comments and/or recommendations: _____

_____

Parent/Guardian Release of Information (Required):
I acknowledge that this referral is being submitted on my behalf by the referring party. I authorize the release of my child's educational and medical records; along with family information pertaining to the well-being of my child and family for participation is the Head Start program.

The following persons/agencies are allowed to share information with the CAP-Head Start program.
___ Child Care Provider: _____
___School District (ECFE, ECSE, Screening, etc.): _____
___ Social Services: Circle one: Scott Carver Dakota Case Worker:_____
___Health Care Provider: _____
___Mental Health Provider: _____

Parent/Guardian Signature: _____ **Date:** _____

*****Return form to our program email address at headstart@capagency.org*****

For CAP Agency Head Start use only:

Date received_____ by_____

_____1. Copy added to application

_____2. Copy sent to the following component staff: _____