



## Cribs for Kids® Program Prenatal Referral Form

**\*\*This referral was completed (check one)  In-person or  Remotely**

Today's date: \_\_\_\_\_

Baby's due date: \_\_\_\_\_

Please complete ALL sections of this referral form and fax to (516)227-9644. In order to refer a prenatal client for a crib, the mother must be within 8 weeks of her due date. After the DOH approves the referral, the referring agency is responsible for completing the safe sleep education and related forms within 2 business days. The referring agency is responsible for completing the safe sleep education and related forms within 2 business days of approval.

### Parent/Guardian Information:

Name of Mother/Guardian: \_\_\_\_\_

Maternal Birth Date: \_\_\_\_\_

Relationship to this child: \_\_\_\_\_

# and ages of children this household: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this residence:  permanent  temporary

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Secondary Contact Information: Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

All forms available at: <http://www.nassaucountyny.gov/3765/Partners> for printing.

Submit completed forms via fax to 516-227-9644

Demographic Information:

**Maternal Education Level:**  Some high school  2-year community college graduate  
 High school graduate  4-year college graduate  
 G.E.D. certificate  Graduate school  
 Other, please explain \_\_\_\_\_

**Race:** *(check all that apply)*  Asian  Black  White  American Indian  
 Asian/Pacific Islander  Other

**Ethnicity:**  Hispanic  Non-Hispanic

**Environmental Smoke:**

A. Did Mother ever smoke during pregnancy: Yes/No (circle one)

B. Will Mother smoke after pregnancy: Yes/No (circle one)

Identify location  inside  outside

C. Do members of household smoke: Yes/No (circle one)

Identify location  inside  outside

Eligibility:

**Are you working now?**  Yes  No  Maternity leave

**Is anyone else in your household working?**  Yes  No

**Is your family receiving any of the following benefits?** *Check all that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> TANF               | <input type="checkbox"/> Disability        |
| <input type="checkbox"/> WIC                | <input type="checkbox"/> SSI               |
| <input type="checkbox"/> Food stamps/SNAP   | <input type="checkbox"/> Section 8 housing |
| <input type="checkbox"/> Child Care Subsidy | <input type="checkbox"/> Unemployment      |

**Health Insurance Mother:**  Yes  No

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11/2024

**Referral Source:**

**Referring Agency:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**Date of Referral:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Any other information you would like us to know:**

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**Agreement for Referral:**

I agree to allow \_\_\_\_\_ to provide my referral information to the Nassau County Cribs for Kids® Program to obtain a crib for my baby. I understand that this does not guarantee that I am eligible to receive a crib. I understand that my information will be kept confidential and may be used to plan education and programs to reduce the risk of infant death. I understand that I will be contacted by the Cribs for Kids Program and its' partners in the future for follow-up. I understand that the safest place for my baby to sleep is on their back in a safety-approved crib. I am aware that this crib cannot be returned to the store for money.

Mother or Guardian of Baby \_\_\_\_\_ Date \_\_\_\_\_

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Does parent want the safe sleep literature that comes with the crib in English or Spanish? \_\_\_\_\_