



Cribs for Kids® Program Postpartum Referral Form

****This referral was completed using: In-person protocol or Covid protocols**

Today's date: _____

Baby's date of birth: _____ (must be <9 months of age)

Please complete ALL sections of this referral form and fax to (516)227-9644. After this form is received, and the client is approved, we will contact you to schedule crib pick-up. The referring agency is responsible for completing the safe sleep education and related forms within 2 business days of crib pick-up (or if using COVID protocols, submitting proof of safe sleep training *prior* to crib pick up).

Parent/Guardian Information:

Name of Mother/Guardian: _____

Maternal Birth Date: _____

Name of infant: _____

Relationship to this child: _____

and age of children in this household: _____

Address: _____ City
_____ State _____ Zip _____

Is this residence: permanent temporary

Home Phone Number: _____ Cell Phone Number: _____

Secondary Contact Information: Name _____ Relationship: _____

Phone Number: _____

Infant Information:

Was your baby born early? ___ Yes ___ No If yes, how many weeks early was the baby born? _____

Twin or multiple birth? ___ Yes ___ No

Comments: _____

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

Submit completed forms via fax to 516-227-9644

11/2021

Where does your baby currently sleep? _____

In what position does the baby sleep? Tummy Back Side

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. Has Mother smoked 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

Do you have a:

Crib Pack n' Play Bassinet Other_____

Child Weight: _____ (must be less than 30 pounds for portable crib)

Childs Height: _____ (must be less than 35 inches for portable)

Referral Source:

Referring Agency: _____ **Contact Person:** _____

Date of Referral: _____ **Telephone Number:** _____ **Email:** _____

Any other information you would like us to know:

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 _____

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