



## 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: \_\_\_\_\_

Where does your baby currently sleep? \_\_\_\_\_

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

Submit completed forms via fax to 516-227-9644

9/2023

**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 \_\_\_\_\_ **(insert AGENCY name)** 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? \_\_\_\_\_