DELAWARE HEALTH AND SOCIAL SERVICES

COMMUNITY RESOURCE AND REFERRAL FORM
(Primary Care Providers)

This form enables primary care providers to refer families to early intervention and early childhood special education Including other community services/resources (via Help Me Grow/2-1-1) after a developmental screen is administered.

Please complete the form on the second page.

USE THIS GUIDE AFTER A PEDS SCREEN:

AGE OF CHILD	HIGH RISK	MODERATE RISK
Instructions: Please check the box below that best fits and fax to resource.	PEDS Path A, or M-CHAT failed or 3+ unmet milestones on the PEDS:DM	PEDS Path B or C, M-CHAT pass and <3unmet milestones on the PEDS:DM
☐ **Birth to 3 years**	**Child Development Watch (North)** Call #: (302) 283-7140 Fax# 302-283-7142	**2-1-1/Help Me Grow** Fax #: (302) 482-4462
☐ **Birth to 3 years**	**Child Development Watch (South)** Call #: (302) 424-7300 Fax# 302-422-1363/302-424-2916	**2-1-1/Help Me Grow** Fax #: (302) 482-4462
☐ **3 to 8 years**	**Child Find** (See List below)	**2-1-1/Help Me Grow** Fax #: (302) 482-4462

USE THE INFORMATION BELOW TO REFER TO A CHILD FIND PROGRAM:

Appoquinimink	Kathy Gerstley	302-376-4404/378-5696	Kathy.gerstley@appo.k12.de.us
Brandywine	Joan McNamara	302-479-2600/479-2216	Joan.mcnamara@bsd.k12.de.us
Caesar Rodney	Brook Castillo Adrielle Benini	302-335-5039/335-3705	Brook.castillo@cr.k12.de.us Adrielle.benini@cr.k12.de.us
Cape Henlopen	Susan Berry	302-645-7210	Susan.berry@cape.k12.de.us
Capital	Pam Nichols	302-857-4241/672-1937	Pamela.nichols@capital.k12.de.us
Christina	Dr. Amber Shelton Debra Norton	302-454-2047 302-454-2047 x2	Amber.shelton@Chiristina.k12.de.us Debra.norton@christina.k12.de.us
Colonial	Tammy Wales	302-429-4088/429-4097	Tamara.wales@colonial.k12.de.us
Delaware Early Childhood Center	Dr. Tanya Robinson Tammy Brice	302-398-8945 x101 302-398-8945 x131	tmrobinson@lf.k12.de.us tammy.brice@lf.k12.de.us
Delmar	Christina Fishburn	302-846-9544/846-2793	Christina.fishburn@delmar.k12.de.us
Indian River	Loretta Ewell	302-732-1343/732-1344	Loretta.ewell@IRSD.k12.de.us
Lake Forest	Dawn Troyer	302-284-9611 x123	dltroyer@lf.k12.de.us
Laurel	Zachary Furbay	443-523-0699	Zachary.furbay@laurel.k12.de.us
Milford	Anne Kneipp	302-424-5474	akneipp@msd.k12.de.us
Red Clay	Tina Albanese	302-892-3227	Tina.albanese@redclay.k12.de.us
Seaford	Lisa Doyle	302-629-4587 x2054	Lisa.doyle@seaford.k12.de.us
Smyrna	Carissa Stevens	302-659-6287/653-3146	Carissa.stevens@smyrna.k12.de.us
Woodbridge	Mondaria Batchelor		Mondaria.batchelor@wsd.k12.de.us
Dept of ED (State Coordinator)	Cindy Brown	302-735-4295	Cindy.brown@doe.k12.de.us

This form enables the provider to refer families to the FF :
Child Development Watch
Child Find
Help Me Grow/2-1-1

Are the parents aware you are making a referral? ____

How did you hear about the program? ____

DATE: ____

Child's Name: First _____ Last _____ Birthdate: _____ Medicaid/DHSS Cares# _____

Child's Address: _____ (required) City/State/Zip _____ Home Phone #: _____ (required)

County:_____Sex: ☐Male ☐ Female Child's Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Child's Race (CHECK ALL THAT APPLY): ☐White ☐Black or African American ☐Asian ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander

School District	Primary Language
Mother's Name (required) MCI#	Birth Date Email
Address	Phone #(H) (CELL) (W)
Father's Name MCI#	Birth Date Email
Address (if different than client's)	Phone #(H) (CELL) (W)
Guardian/Foster Parent/Educational Surrogate Name	
Address Phone #(H) (CELL) (W)	

Birth Weight Current Weight	Gestation (weeks) APGARS
PCP/Office	Phone # Fax #
ICD10	

Insurance Information	
Private Insurance Co. Name: _____ Policy Holder: ☐Mom ☐Dad *(MUST include DOB above)* Group/Acct # _____ Member ID# _____ Effective Date:_____ Address: _____ Phone # _____	*IF DELAWARE MEDICAID ONLY - CHECK BELOW:* ☐*MA-Fee For Service/traditional* ☐*MA-Highmark Health Options* ☐*MA-United Healthcare* *Notes:*

Child Care Name Address Phone#

REFERRING AGENCY/PERSON	Phone #	Email:	
☐ PEDS Screener	☐ ASQ	☐ MCHAT	☐ Other screening (please specify): ____

RECEIVING AGENCY ACTION _____ ***DATE*** _____

Reason for referral: ____

CDW North: Call: 302-283-7140 Fax: 302-283-7142

Mail - 258 Chapman Rd, Newark, De 19720
Email – DHSS_DPH_CentralIntake@state.de.us

CDW South: Call: 302-424-7300 Fax: 302-422-1363 or 302-424-2916

Mail to 18 N. Walnut St, Milford De 19963
Email with "Referral" in subject to Dhss_DPH_CDW-SHS@state.de.us