30 Madison Avenue
Springfield, MA 01105
phone: (413) 788-6522
fax: (413) 788-6679
TTY: (413) 733-2785

HCS Head Start, Inc.

EDUCATING children. SUPPORTING families. BUILDING healthy communities.

662 High Street
Holyoke, MA 01040
phone: (413) 536-0363
fax: (413) 536-0928
TTY: (413) 532-2496

Agency Referral Form

Date of Referral: _____

Child Name: _____ **DOB:**_____

Parent Name: _____**Phone:** _____

Address: _____

Name of Referring Agency: _____

Agency Contact Name: _____ **Title:** _____

Agency Phone: _____ **Cell/Other Phone**: _____

Is the family aware of the referral? ☐Yes ☐No

Reason for referral: _____

_____

_____

Please indicate all that pertains to child/family:

☐ Homeless ☐ Foster ☐ Suspected Disability ☐ Diagnosed Disability

☐ IEP/IFSP ☐ DCF Involved ☐ Housing Authority Resident ☐ Mental Health Concerns

☐ Needs Translation (specify language) _____

Information Parent/Guardian will need to bring to HCS Head Start, Inc.

<u>Age Eligibility Verification</u> (Birth Certificate, medical record, or other proof of DOB):

☐ Early Head Start- Prenatal to 2.9 years old
☐ Head Start-2.9 years old to 5 years old (must not be eligible for kindergarten)

- **Record of child's current physical, immunizations *and* IEP/IFSP (if applies)**
- **Current proof of public assistance: SSI or TAFDC letter dated within 30 days *or***
- **Proof of family income for the *past year* including: paystubs, tax return, W-2's, letter from employer, child support statement or notarized letter (*dated within 30 days*) *or***
- **Proof of homelessness or foster care**

If you would like to communicate with us regarding the status of this referral, please have the parent complete the authorization to release on the back of this form

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AUTHORIZATION TO RELEASE INFORMATION

I hereby give permission to HCS HEAD START, INC. and _____
(Referring Agency)

to release and exchange any information, both written and verbal, pertaining to the records for the

enrollment of, _____, ____/____/____.
(Child's Name) (D.O.B.)

Signature of Parent/Guardian_____ Date _____

Reviewed verbally in Parent/Guardian Primary Language _____
Initials

This authorization form expires one (1) year from the date signed. You have the right to revoke this release in writing at any time

Please fax or drop off to:

HCS Head Start, Inc.
130 Maple Street, Suite 204
Springfield, MA 01103
413-417-7779/Fax 413-455-2786

HCS Head Start, Inc.
662 High Street
Holyoke, MA 01040
413-536-0363/Fax 413-536-0928

Forms and applications can also be mailed to:

HCS Head Start, Inc.
30 Madison Avenue
Springfield, MA 01105

HCS Head Start, Inc.
662 High Street
Holyoke, MA 01040

All forms and information requested are the property of HCS Head Start, Inc., and may not be reproduced for anything other than their intended purpose.
Revised 10/30/18