Healthy Outcomes through Prevention and Early Support

For Official Use Only:

Referral ID #:______________________

Referring Agency Information:

Name: ____

Address:____

Phone:_______________________________ • Email:______________________________________

Parent Information:

Name: ____

Address:____ • Email:______________________________

Phone:___________________________________ Best time to contact (day and time):__________________

Does parent live in Travis or Williamson County? ◻ Yes ◻ No Zip Code:______________________

Does parent currently engaged in an open CPS case? ◻ Yes ◻ No

Has the family had or have a substantiated CPS case? ◻ Yes ◻ No

Primary child name:______________________________ Primary Child Date of Birth:___________________

Number of children, ages 0-5, living in the home: _____ Number of children (6+) living in the home:________

Preferred language (check all that apply): ◻ English ◻ Spanish ◻ Other: _____________________________

Preferred service type: ◻ Individual Session ◻ Group Session ◻ No Preference

Eligibility Factors (Check all that apply):

◻ Difficulty with parent/child interaction ◻ Parent/Guardian and/or child suffers from depression/anxiety
◻ Teen parent ◻ High parent conflict/separation/divorce ◻ High general stress level
◻ Parent/Guardian has high frustration level with child's behavior
◻ Parent/Guardian would benefit from child development education
◻ Social isolation of family/parent/guardian-lack of support ◻ Homelessness
◻ Non-traditional family structure-especially single parent with lack of social support and/or a high number of children in the household

Additional Factors (Check all that apply):

◻ Survivor of domestic violence ◻ Parenting a child with special needs ◻ Low income
◻ Parent experienced maltreatment in childhood ◻ Substance abuse ◻ Low education

I ______________ (parent name) give permission for _________________ (referring agency) to give the following contact information to Project HOPES staff as part of a referral process to the Project HOPES Program. I agree for my contact information to only be utilized for referral purposes and only to be released to Project HOPES staff.

Parent Signature: ____ Date:__________________

Contact: Project HOPES Referral Specialist • **E-mail:** projecthopes@safeaustin.org • **Phone:** 512-264-4100 • **Fax:** 512-320-1901