



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: _____

Is 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: _____