Dad Information

Name _____
First M.I. Last

Date of Birth: _____ Primary Phone Number: _____

Other Phone Number: _____ Email Address: _____

Street Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Language(s) Spoken: ☐ English ☐ Spanish ☐ Haitian Creole ☐ Other:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widower

Does the participant have any children? ☐ No, this is/will be first child ☐ Yes, has other children (#_____)

Name of Parent/Guardian: _____ Relationship to Participant _____
(if under the age of 18)

Mom and Infant/Child Information (If Available)

Mom Name: _____ Mom DOB: _____

Child/Infant Name: _____ Infant/Child DOB: _____

Referral Reason: ☐ Mother is in Healthy Start ☐ Mother is in other Home Visiting Program
☐ Mother is pregnant and NOT receiving any Home Visiting Services
☐ Infant/Child is in Healthy Start ☐ Infant/Child is in other Home Visiting Program
☐ Infant/Child is NOT receiving and Home Visiting Services

Referral Information

Person Making Referral: _____ Date Referred: _____

Agency/Program: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Best way to contact Dad: _____

Father Consents to the following contact methods:

☐ Phone ☐ Email ☐ Text Message ☐ Home Visit

Release of Information Consent

I,_____(print name of dad or minor dad's legal guardian), give my permission for _____ (person making referral), to share any and all pertinent information regarding me or my child, _____ (print dad's name) with the T.E.A.M Dad Program listed above and the Referring Agency to learn more about the program and determine eligibility.

I have read this Consent before signing and fully understand the contents, meaning and impact. I understand that I am free to address any specific questions and have done so prior to signing this Consent. I understand that I have the right to revoke my consent by informing representatives from the T.E.A.M. Dad program.

Signature: _____ Date: _____
(☐ Participant or ☐ Parent/Legal Guardian)

If Verbal Consent is Provided

Verbal Consent Obtained By: _____ Date: _____

Signature: _____ Date: _____

Fax To: (786) 565-4013 OR Email to: referrals@hscmd.org