

**REFERRAL MEMORANDUM**  
**(HEAD START/OPP, EARLY HEAD START, HEALTHY START)**

DATE: \_\_\_\_\_

TO: Ana Reynaud, Family Services Manager  
Umatilla Morrow Head Start  
110 NE 4<sup>th</sup> St., Hermiston, OR 07838

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUBJECT: Referral for: \_\_\_ Head Start/OPP \_\_\_ Early Head Start \_\_\_ Healthy Start

Name of Child \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address/City, State/Zip Code \_\_\_\_\_

The above child/family is being referred to Head Start/OPP/Early Head Start/Healthy Start. The child/family has concerns and issues that can best be served through the comprehensive program that UMCHS provides. Indicated below is information that will assist you in the assessment and determination of eligibility for your program.

- |  |   |
|--|---|
| <input type="checkbox"/> First time parent/pregnancy (Healthy Start)                             | <input type="checkbox"/> Baby is newborn to 6 weeks old                                       |
| <input type="checkbox"/> Child is age 6 wks. To 35 months (EHS)                                  | <input type="checkbox"/> Child will be 3 or 4 on or before Sept. 1 <sup>st</sup> (HS)         |
| <input type="checkbox"/> Parent/Guardian receives SSI  | <input type="checkbox"/> Parents work full time   |
| <input type="checkbox"/> Single Parent   | <input type="checkbox"/> Socially/Culturally isolated family                                  |
| <input type="checkbox"/> Teen Parent   | <input type="checkbox"/> Homeless or Housing concerns   |
| <input type="checkbox"/> Low Income  | <input type="checkbox"/> Parent(s) are in an education training or work experience program    |
| <input type="checkbox"/> Unemployed two-parent family  | <input type="checkbox"/> Parents have DHS Self-Sufficiency Personal Development Plan in place |
| <input type="checkbox"/> Family in crisis  | <input type="checkbox"/> Family has minimal education   |
| <input type="checkbox"/> History of Child Abuse/Neglect  | <input type="checkbox"/> History of Mental Health Issues                                      |
| <input type="checkbox"/> History of Domestic Violence Issues                                     | <input type="checkbox"/> History of Substance Abuse/Alcohol Issues                            |
| <input type="checkbox"/> Current involvement with Dept. of Corrections                           | <input type="checkbox"/> Medical, Dental, Nutritional Concerns (Circle all that apply)        |
| <input type="checkbox"/> Child Documented with a Disability or Special Need (Circle which) _____ | <input type="checkbox"/> Behavior Issues _____  |
| <input type="checkbox"/> Head Start/OPP/EHS Application attached                                 | <input type="checkbox"/> Additional Information attached                                      |

Thank you for your consideration in selecting this child for your program. Please contact me if you have questions or need more information.

\_\_\_\_\_  
Signature and Telephone # of person making referral

I give my permission for the above information to be shared with Umatilla Morrow Head Start, Inc.

Signature of Parent/Guardian \_\_\_\_\_