VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

REFERRAL
FORM-CIS-01
Version 02-23

Children's Integrated Services:

Strong Families Vermont, Early Intervention, Early Childhood & Family Mental Health, & Specialized Child Care

The Potential Family/Caregiver/Client has given verbal permission for this referral: ☐ Yes ☐ No:
(Obtaining verbal permission before making a referral is required, except in CAPTA cases)

A. CONTACT INFORMATION for INDIVIDUAL(S) BEING REFERRED

Client's Name: Client's Date of Birth: Pronouns: Gender: M F

Client Identified Ethnicity: ☐ Hispanic/Latinx or of Spanish origin of any race ☐ Non-Hispanic/Latinx/of Spanish origin

Client Identified Race: ☐ American Indian/AK. Native ☐ Asian ☐ Black/African Amer. ☐ White ☐ 2 or More Races ☐ Other as Identified by Client/Family:

Note: *This information is only used by the State to meet federal grant reporting requirements, not to determine services.*

Client is a: Child Care Program Pregnant Person Child (Parent/Guardian's Name)

Primary Language: Is Interpreter Needed? ☐ Yes ☐ No	Pregnant Person's Anticipated Due Date: Best Way to Contact Client:
Mailing Address:	Physical Address:
Phone (Home/Work/Cell): ext:	Email:

Custody: Parent(s) Foster Parent(s) FSD Contact: ☐ Legal Guardian ☐ Kin (no legal status)

B. REASON FOR REFERRAL

For Child:

- ☐ Health
- Developmental Concern, Delay or Disability
  - Hearing / Vision
  - Cognitive
  - Behavioral
  - Adaptive
  - Communication
  - Social / Emotional
  - Motor / Physical
  - Other:
- Family Services substantiated abuse/neglect (CAPTA)
- Risk/History of Abuse / Neglect / Family Violence
- Nutrition, Diet, or Feeding
- Significant Birth Issues
- Sleep Concerns
- Inclusive Child Care Access
- Diagnosed Condition:
- Other:

For Adult/Parent/Guardian/Child Care Program:

- ☐ Specialized Child Care Financial Assistance
- ☐ Parent/Guardian Questions about Child Care
- Child Care Provider Questions
- Health of Parent/Expectant Parent
- Lactation/Breastfeeding Questions/Support
- Parenting Questions/Concerns
- Prenatal Questions/Concerns
- Postpartum Questions/Concerns
- Substance Use/History
- Domestic Violence
- Homelessness/Unstable Housing
- ☐ Consultation or Training for Child Care Program
- Other:

C. ADDITIONAL COMMENTS

D. REFERRAL SOURCE INFORMATION

Person Making Referral: Referral Date:
Agency/Organization: Phone: ext:
Address: Email: Role:

E. MEDICAL PROVIDER INFORMATION (If different from Referral Source)

Provider Practice Name:
Provider/Physician Name: Phone: ext:

Client Insurance: ☐ Medicaid/Dr. Dynasaur ☐ Private Insurance ☐ Both Private and Mediciad ☐ Uninsured ☐ Unknown
Medicaid ID#: Private Insurance Carrier:

THANK YOU • PLEASE SUBMIT THIS FORM TO YOUR REGIONAL CIS COORDINATOR

For Internal Use Only:
Date Received: Received By: Date of Initial Contact: