Safe and Healthy Homes Program - Provider Referral and Participant Consent Form

Date: _____ Referred by: _____

PART 1- Eligibility *(must be YES to #1 & 2 for family to be eligible)*

1. Is there an expecting mother or a child up to 21 years old in the household? **Yes** **No**

2. Does the household participate in/is eligible for any assistance programs such as WIC, LIHEAP, Medicaid, free or reduced price school lunch, Nurse Family Partnership, Cash Assistance or is otherwise known to be below 300% of the Federal Poverty Guidelines? **Yes** **No**
   a. If so, please provide details (i.e. which specific program; income verification)_____

PART 2- Additional Information

1. Name of expecting mother/child: _____
2. Child's age (or pregnant mother's due date):_____
3. Name of caregiver (if applicable): _____
4. Preferred phone number(s): _____
5. Home address: _____
6. Email address/other contact information: _____
7. Does the caregiver primarily speak a language other than English? **Yes** **No**
   a. If yes, what language? _____
8. Does the expecting mother and/or the child suffer from asthma? **Yes** **No**
9. Is the household concerned about pests (e.g., roaches, mice, bed bugs, etc.)? **Yes** **No**
10. Is the household concerned about home safety or injuries (from falls, fires, etc.)? **Yes** **No**

For data analysis purposes only:

Race: Black or African American____ White____ American Indian or Alaska Native____ Asian____

Native Hawaiian or Pacific Islander____ Two or more races____ chose not to answer____

Ethnicity: Non-Hispanic or Latino____ Hispanic or Latino____ chose not to answer____

Please return this form, with the caregiver consent form, to Janine Lee by fax at 610-521-8928 or email at jlee@caadc.org or you may call 610-521-8770 x 100 to complete this referral over the phone.

Please see caregiver consent on page 2.

Caregiver Consent

The Safe and Healthy Homes Program (SHHP) serves to reduce illness and injury caused by home health and safety hazards, such as fire and fall hazards and asthma triggers like pests and mold. SHHP is funded through the Pennsylvania Department of Health.

My signature below indicates that I consent to be referred to this program and that I understand the following:

1. I consent to the above provider releasing only the information contained on this Provider Referral and Participant Consent form to the SHHP staff.
2. My participation in this program is voluntary.
3. I can expect to be contacted by the SHHP staff serving the region in which I live as soon as possible.

Signature of Caregiver: _____ Date: _____