



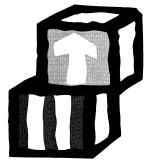
# HEAD START

Serving Scott, Carver and Dakota Counties

712 Canterbury Road  
Shakopee, MN 55379  
952-496-2125  
Fax 952-402-9815

110650 Village Road  
Chaska, MN 55318  
952-960-9700  
Fax 952-960-9699

2496 145<sup>th</sup> St W  
Rosemount, MN 55068  
651-322-3500  
Fax 651-322-3555



## Referral to CAP Agency Head Start

Name of person referring _____	Date of Referral _____
Agency _____	Phone _____
Address _____	City/State/Zip _____
Child's Name _____	Birth Date _____
Parent's Name _____	Phone _____
Address _____	City/State/Zip _____

### Reason for referral

1. What life events apply to this *family*? Check all that apply. Family members include anyone living in the home.

- |   |  |
|---|--|
| <input type="checkbox"/> Chemical abuse in the home                                   | <input type="checkbox"/> Divorce and/or separation of parents                    |
| <input type="checkbox"/> Physical abuse—current or in the past                        | <input type="checkbox"/> One or both parents is totally absent from child's life |
| <input type="checkbox"/> Verbal abuse—current or in the past                          | <input type="checkbox"/> Addition of step-parent to family                       |
| <input type="checkbox"/> Sexual abuse—current or in the past                          | <input type="checkbox"/> Recent birth of sibling                                 |
| <input type="checkbox"/> Death of a parent, brother, sister, other primary care-giver | <input type="checkbox"/> Parent beginning work or school                         |
| <input type="checkbox"/> Jail sentence of family member                               | <input type="checkbox"/> Addition of unrelated adult to household                |
| <input type="checkbox"/> Child has visible or congenital deformity                    | <input type="checkbox"/> Loss of job by a parent                                 |
| <input type="checkbox"/> Serious illness of family member                             | <input type="checkbox"/> Change in parent's financial status                     |
| <input type="checkbox"/> Inadequate housing, homeless, hazardous housing              | <input type="checkbox"/> Low-income with financial struggles                     |
| <input type="checkbox"/> Increase of chemical use by family member                    | <input type="checkbox"/> Recent move to a new home                               |
| <input type="checkbox"/> Developmentally challenged family member                     | <input type="checkbox"/> Child has documented special needs                      |
| <input type="checkbox"/> Parent or primary care-giver with mental illness             | <input type="checkbox"/> Other (Please explain below)                            |
| <input type="checkbox"/> Other household member (not parent) with mental illness      |  |

Give us as much information as possible to help us understand stress within the family that may interfere with this child's normal, healthy, growth and development. Use additional paper if necessary.

2. Do you have concerns about this *child's* development? Check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Social/Emotional Development or Mental Health   | <input type="checkbox"/> Speech or Language    |
| <input type="checkbox"/> Physical Development (Health, Nutrition, Growth, Balance, Sensory, Large Motor, Fine Motor etc) | <input type="checkbox"/> Cognitive Development |
|  | <input type="checkbox"/> Other                 |

Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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3. Has this child been evaluated for special education services? No / Yes

If the child was evaluated, did the child qualify for special education? No / Yes\*

\*Diagnosis \_\_\_\_\_ \*District providing services \_\_\_\_\_

Comments: \_\_\_\_\_

4. Does this child have diagnosed health risks that may impact ability to learn or require school accommodations? No / Yes\*

\* Explain \_\_\_\_\_

5. Additional comments and/or recommendations: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail or fax this form to:** CAP Agency Head Start – Attn: Julie Schulz  
2496 145<sup>th</sup> St W, Rosemount MN 55068  
Fax (651) 322-3555  
*If you have additional questions, contact Julie at 651-322-3519.*

**For CAP Agency Head Start use only:**  
Date received \_\_\_\_\_ by \_\_\_\_\_  
This referral is for (check all that apply) \_\_\_\_\_ Head Start Plus ♦ \_\_\_\_\_ Special Education †  
📁 \_\_\_\_\_ 1. Copy to application in-take Shakopee / Rosemount (Circle one) Intake: Attach to HS app, write referral on front  
♦ \_\_\_\_\_ 2. Copy to FSC (name) \_\_\_\_\_  
† \_\_\_\_\_ 3. Copy to Special Needs Coordinator (name) \_\_\_\_\_  
\_\_\_\_\_ 4. Copy to other as needed (ex. Health Coordinator) \_\_\_\_\_  
📁 A copy *must* be sent to application in-take and be attached to the child's Head Start application.