

Parent Support Outreach Program Referral

****Indicates Required Information***

****Please note this form must be accompanied by a signed Consent for Enrollment****

Parent(s) Name*: _____

Mother's DOB*: _____ Father's DOB*: _____

Address*: _____

Directions to Home: _____

Telephone*: _____ Cell: _____

Name of Child(ren)*	Date of Birth*	School Attended (if any)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

(List additional family members/children on the back of this form)

Do you know if this family is or has been involved with Family Outreach or Caring Connections? If so, please indicate the name of the service provider, if known: _____

***Identified stress factors being experienced by the family (check all that apply)*:**

<input type="checkbox"/> Single or first time parent(s) with limited support systems	<input type="checkbox"/> Family income is at or below poverty level
<input type="checkbox"/> Lack of Parenting Skills/Parenting Challenges	<input type="checkbox"/> Premature and low birth weight infants
<input type="checkbox"/> Child(ren) with special health needs	<input type="checkbox"/> Parent(s) with mental health or developmental issues
<input type="checkbox"/> Parent(s) with a history of chemical use/abuse	<input type="checkbox"/> Parent with a history or symptoms of post partum depression
<input type="checkbox"/> Families experiencing or have a history of domestic violence	

***Please provide a brief summary of the concerns or issues this family is experiencing or may experience in the near future if services are not provided: (please be specific):**

MAIL OR FAX this completed form **AND** the signed Consent for Enrollment to:
Brad Vold, Otter Tail County Human Services
530 W. Fir Avenue, Fergus Falls, MN 56537
Fax: 1-218-998-8213