COMMUNITY ACTION PARTNERSHIP
OF SCOTT CARVER & DAKOTA COUNTIES

Head Start
www.capagency.org

712 Canterbury Road S.
Shakopee, MN 55379
952-496-2125
952-402-9815 (fax)

2496 145th Street West
Rosemount, MN 55068
651-322-3500
651-322-3555 (fax)

Referral to CAP Agency Head Start 1308.5(a), 1305.6(c), 1305.7(11)(aa)

Name of person referring______________________ Date of Referral___________________________

Agency______________________________________ City____________________________________

Email Address________________________________ Phone __________________________________

Check One: ☐ I've given Head Start application to family ☐ Please mail Head Start application to family

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.

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

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.

- ☐ Social/Emotional Development or Mental Health
- ☐ Physical Development (Health, Nutrition, Growth, Balance, Sensory, Large Motor, Fine Motor etc)
- ☐ Speech or Language
- ☐ Cognitive Development
- ☐ 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 Intake
2496 145th St W, Rosemount MN 55068
Fax (651) 322-3555

For CAP Agency Head Start use only:

Date received________________ by____________________________________

This referral is for (check all that apply) ________ Other ________Special Education✦

🗁_____1. Copy to application in-take _Shakopee / Rosemount_ (Circle one) Intake: Attach to HS app, write referral on front

✦ _____2. Copy to Special Needs Coordinator (name) ____________________________________

_____3. 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.