

Cribs Post:

Car Seat Post:

Pick-up Date:

Pick-up time:

**Referral Form for Cribs for Kids® Program and Kids in Safety Seats Program**

Contact Natalie Hall at [nhall@howardcountymd.gov](mailto:nhall@howardcountymd.gov) or 410-313-6295 with questions.

**CHECK WHICH PROGRAM(S) THE FAMILY IS BEING REFERRED TO:**

Cribs for Kids®

Kids in Safety Seats

**For Completion by Referring Staff Member:** *Please fill out this form completely with your client.*

Date of Referral: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Staff Name, Phone #, & Email: \_\_\_\_\_

Need of Client (brief description of family circumstances to support need): \_\_\_\_\_

**Eligibility Guidelines:** *(Check all that apply)*

- Howard County Resident (Required)
- MD Children’s Health Program/Medical Assistance/Medicaid Card
- Howard County WIC Recipient
- Supplemental Social Security Income (SSI/SSDI) recipient
- Temporary Cash Assistance/Food Stamps/SNAP
- Unemployment Benefits
- Other:

Does the client have a safe crib, bassinet, or pack-n- play?  Yes  No

Does the client have a toddler bed for their child(ren) ages 2 to 4?  Yes  No

Does the client have a car seat or booster seat for their child(ren) ages birth to 8 years old?  Yes  No

**Recipient’s Information:**

Name of Client: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Interpreter Needed?  Yes  No

Email (Required): \_\_\_\_\_ Phone # (Required): \_\_\_\_\_

The client gives consent for staff to send texts messages related to this referral to the cell phone number provided above.

Yes  No

Due Date: \_\_\_\_\_ OR Child’s DOB: \_\_\_\_\_

Child’s Estimated Weight: \_\_\_\_\_ Child’s Estimated Height: \_\_\_\_\_

Email completed referral form to [nhall@howardcountymd.gov](mailto:nhall@howardcountymd.gov)

*\*CAREAPP users are to upload this completed referral form to your CAREAPP referral.\**

***Incomplete referral forms will be returned to the sender.***

