Kentucky Public Health
Prevent. Promote. Protect.

Kentucky HANDS
Health Access Nurturing Development Services
Every family needs an extra pair of HANDS.

Participant Name:	
Identification #:	
Clinic #:	

Local HANDS Agency Information	
Agency Name:	
Contact Person:	
Phone:	Fax:
Email:	

HANDS is a voluntary program for all families. Babies deserve safe, healthy, and happy childhoods, and we can support you in reaching this goal. This referral is the first step to help determine if HANDS might be a good fit for your family. Enrollments must occur within 90 days of baby's birth.

Parent/Legal Guardian Information

First Name:	MI:	Last Name:	SSN:
Previous HANDS Participant: ☐Yes ☐No ☐Unknown			
Address:			
City:	Zip:	County of Service:	
Primary Phone: ( ) Leave messages? ☐ Yes ☐ No ☐ N/A Text? ☐ Yes ☐ No ☐ N/A			
Alternate Phone: ( ) ☐ N/A Leave messages? ☐ Yes ☐ No ☐ N/A Text? ☐ Yes ☐ No ☐ N/A			
Relationship to Baby: ☐ Birth Mother ☐ Birth Father ☐ Guardian/Custodian other than birth parent			
Estimated Date of Delivery (complete for prenatal AND postnatal):			
Delivery Date (if applicable):	Baby's Name (if applicable):		
What primary language is spoken in the home? Is an interpreter required? ☐ Yes ☐ No			

Referral Information

Date of Referral: _____

Please select how the participant learned about HANDS or which type of agency you represent from the list below.

- ☐ Church/Community Organization
- ☐ Community Based Services
- ☐ Family Resource Center/School
- ☐ Family/Neighbor/Friend
- ☐ Head Start
- ☐ Health Department
- ☐ Hospital
- ☐ OB/GYN
- ☐ Other (List) _____
- ☐ Physician
- ☐ Self-Referral

Referral Source

If this is not a self-referral, please complete the following information.

Name: _____ Agency: _____

Phone and/or Email: _____

Does the family know you are making a referral on their behalf? ☐ Yes ☐ No

Please return completed referral to your local HANDS Program via the contact information listed above.

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HANDS STAFF USE ONLY		
Date Referral Received by HANDS Staff:		
Contact Attempts		
Date	**Type of Contact**	**Notes**

Additional Information

If an assessment is not completed, indicate reason: ☐ Forwarded Referral to Another LIA (List):_____
☐ Refused ☐ Adoption ☐ No Response ☐ Infant Death ☐ Still Birth (Fetal Death) ☐ Other (List):

Were community resources provided? (Select N/A for "No Response") ☐ Yes ☐ No ☐ N/A

Was a referral made to another home visiting program? ☐ Yes ☐ No
If yes, check all that apply: ☐ FRYSC ☐ Early Head Start ☐ DCBS ☐ Other:

Data Entered: _____ /_____ /_____ Initials:_____