south dakota BIRTH TO THREE
The first three years build a lifetime

INTAKE FORM

Date Referral Received:_____

SOURCE OF INTAKE REQUEST

Name of referring person/agency: _____ Phone: _____

FAMILY INFORMATION

Child's name: _____ Male☐ Female☐ DOB____/____/____

Child's Address:_____

Guardian:*(If other than parent)*_____

Mother's name: _____ Phone: (H) _____ (W) _____

Address: _____

Father's name: _____ Phone: (H) _____ (W) _____

Address: _____

Directions to family's home: _____

Medical Diagnosis *:(If any)*_____

Family physician:_____ Phone: _____

CONCERNS OF REFERRAL SOURCE

_____

CONCERNS OF PARENTS

_____

CURRENT SERVICES (check all apply)

☐ Childcare Services
☐ CHIP (Children's Health Insurance Program
☐ Children's Special health Services
☐ Energy Assistance & Weatherization
☐ Family Support Program
☐ Food Stamps
☐ Head Start/Early Head Start
☐ Home Health Care
☐ Legal Aid
☐ Medicaid
☐ Medical Insurance
☐ Mental Health Counseling
☐ Parenting Classes
☐ Preschool Services
☐ Respite Care Program
☐ Shriners
☐ SSI
☐ Subsidized Housing
☐ Support Groups
☐ TANF
☐ WIC

Other

_____