

Referral Form

To: **Nurse-Family Partnership**

Fax: **719-255-8095**

E-mail: **nfp@uccs.edu**

From: Referring Agency: _____

Date: _____

Contact Person: _____

Phone #: _____

Re: **The following pregnant woman would like to be contacted to receive more information about the Nurse-Family Partnership Program.**

Client Info:

Name (Nombre)

Date of Birth (Fecha de Nacimiento)

Due Date (Fecha de Parto)

Primary Phone # (Teléfono Primario)

Alternate Phone # (Teléfono Alternativo)

Address (Domicilio)

Apt # (Calle y #Apto)

City (Ciudad)

Zip (Código Postal y Condado)

Primary Language (Idioma Principal)

Comments:

PROGRAM & REFERRAL INFORMATION

QUESTIONS TO ASK IF MAKING AN NFP REFERRAL

If you answer yes to the questions below please give your client an NFP brochure and make a referral.

Select one

Is your client pregnant with her first child or delivered within 30 days? YES NO

Does your client live in El Paso or Teller County? YES NO

Does your client meet the low-income criteria (see below) or are they currently on WIC or Medicaid? YES NO

NFP Income Guidelines = 200% Poverty Level

Source: Federal Register January 26, 2017 (<https://aspe.hhs.gov/poverty-guidelines>)

<u>Family Size</u> (Include client & unborn baby/babies only)	Client + 1 unborn baby	Client + unborn twins	Client + unborn triplets
	2	3	4
Maximum Annual Gross Income	\$32,480	\$40,180	\$49,200
Maximum Monthly Gross Income	\$2,707	\$3,348	\$4,100

ABOUT NFP:

- Nurse-Family Partnership (NFP) is a free program for first-time mothers.
- In this voluntary program, a personal nurse will visit women at any location of their choice (home, school, library, mall, etc.) starting as early as possible during pregnancy.
- The nurse will support new mothers in:
 - ✓ Having a healthy pregnancy.
 - ✓ Teaching and practicing things that help a mom become confident, like breastfeeding, nutrition, child development, safe-sleep techniques and much more.

PROGRAM GOALS:

- Improve pregnancy outcomes
- Improve child health and development
- Improve the economic self-sufficiency of the family

NFP USE ONLY

Nurse Assigned: _____ Date Assigned: _____

NHV Contact Attempts (return form to Data Entry when completed)

Date of Contact	Type of Contact/Contact Notes

Referral Disposition

Enrolled/First Visit	Unable to Locate	Refused Participation	Did Not Meet Program Requirements	Program Full
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____