healthy families
MONTGOMERY & SCHOHARIE COUNTIES
Programs of CAN

1230 Riverfront Center - Amsterdam, NY 12010 | Phone: (518) 317-2553 | Fax: (518) 684-5816

Today's Date: _____

Parent 1/ Caregiver 1's Name: _____ DOB: _____**Phone #:** _____
Street Address: _____City: _____Zip: _____

Parent 2/ Caregiver 2's Name: _____DOB: _____Phone #: _____
Street Address: _____City: _____Zip: _____

Estimated Due Date or Date of Delivery: _____

Email Address: _____

How do you prefer to be contacted? *(check all that apply)* ❑ Text ❑ Phone Call ❑ Email
Is it okay to leave voicemails on your phone? ❑ Yes ❑ No

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1. Choose the one that best applies:

❑ Married ❑ In a Relationship/Unmarried ❑ Single ❑ Divorced/Separated ❑ Widowed

2. When did your prenatal care begin?:

❑ 1-12 weeks ❑ 13-24 weeks ❑ 25-40 weeks ❑ No Prenatal Care

3. Which services do you currently receive?

❑ WIC ❑ SSI/SSD ❑ SNAP (formerly known as food stamps) ❑ HEAP ❑ Medicaid ❑ Public Assistance
❑ None ❑ Other: _____

4. Who can you count on for support?:
❑ Partner ❑ Parents ❑ Grandparents ❑ Other Family ❑ Friends ❑ No One ❑ Other: _____

❑ Please do not contact me (by checking this box you are stating that you do not want anyone from Healthy Families to contact you)

By signing, I understand that a representative from the Healthy Families Montgomery-Schoharie Counties program will contact me with more information.

Signature: _____ Date: _____

Referral Information

Referral Source 's Name: _____Phone Number: _____

Referral/Recruitment Source *(Check Only One)*:

❑ Private Physician ❑ Health Clinic ❑ Hospital ❑ WIC ❑ DSS/CPS ❑ Home Visiting Program ❑ Visiting Nurses
❑ Home Health Care Agency ❑ Church ❑ Community Based Organization ❑ School ❑ Daycare Center
❑ Friend/Family ❑ Other:_____