INQUIRY FORM

Due to contract and/or program requirements, we may need to contact you to gather more information to complete a referral.

If you would like to speak with our referral team, feel free to call 206-957-4841 or email referrals@childhaven.org.

Fax this completed form to 206-433-8566.

Program Key *Please note that not all programs may be available due to contract requirements or location*

Flourish (ECLIPSE + WISe)

- Therapeutic Child Care with Wraparound Services
  - Requires DCYF Social Worker, CSO, Public Health Nurse, or Primary Care Provider approval
  - Ages 1 month – 5 years
  - King County Medicaid accepted only

Head Start / ECEAP

- Early Learning
  - Ages 3 (by August 31st of school year) – 5 years

Early Intervention

- Developmental evaluations and therapies for children 0-3rd birthday
  - Private and public insurance accepted

Counseling

- Center-based and in-home (where available) counseling
  - Ages 0-13th birthday
  - King County Medicaid accepted only

Parent/Guardian Information

First Name _____ Last Name _____

Phone _____ Relationship to Child(ren) _____

Current Street _____

Current City _____ Current Zip/Postal Code _____

Primary language(s) in the home _____ Interpreter Needed? _____

Referral Source Information (if not parent or guardian) ☐ Same as above

First & Last Name _____ Phone _____

Referral Source Email _____

Relationship of Referral Source to Child _____

Organization/Agency _____

Have parent(s)/guardians(s) been informed of this referral to Childhaven? ☐ Yes ☐ No

Child(ren) Information (if more than three children, please attached extra pages)

First Name _____ Middle Name _____

Last Name _____ Birthdate _____

Gender: _____ Race/Ethnicity: _____

Insurance Provider: _____ Policy #: _____

Medical Concerns: _____

Program(s) Desired (see key above): _____

_____

First Name _____ Middle Name _____

Last Name _____ Birthdate _____

Gender: _____ Race/Ethnicity: _____

Insurance Provider: _____ Policy #: _____

Medical Concerns: _____

Program(s) Desired (see key above): _____

_____

First Name _____ Middle Name _____

Last Name _____ Birthdate _____

Gender: _____ Race/Ethnicity: _____

Insurance Provider: _____ Policy #: _____

Medical Concerns: _____

Program(s) Desired (see key above): _____

_____

Referral Reasons (Please provide reasons for referral to Childhaven programs)

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