

SAFE CRIBS FOR MISSOURI PROGRAM REFERRAL FORM
Missouri Department of Health and Senior Services, Bureau of Genetics and Healthy Childhood
To be filled out by Local Public Health Agency
Fax to: 573-751-6185

Client's First Name _____ Last Name _____ Maiden Name _____
(Please print) (Please print) (Please print)

Address _____
Street City State Zip

County of residence _____ Phone number (_____) _____

1. Client's date of birth: _____
2. Ethnicity: Hispanic or Latino Not Hispanic or Latino
3. Race: White Black or African-American Asian Native Hawaiian or Other Pacific Islander
 American Indian or Alaska Native Multiracial Don't know Refused Other _____
4. Educational Level of Client: Some high school High school diploma/GED 2 year community college
 4 year college graduate Graduate school Unknown Other, please explain. _____
5. The client is currently: Prenatal Gestational Age _____ (Weeks)
 Postpartum Baby's Date of Birth _____ Baby's full name _____
(Please print)
6. If you do not get a crib from this program, what are the sleeping arrangements for your baby?
 Alone in a full size crib Alone in a bassinet Alone in a portable crib
 In client's bed with others In bed with others Car seat Sofa or chair
7. If using a bassinet, what are the plans once your baby outgrows it? NA
 Alone in a full size crib Alone in a portable crib
 In client's bed with others In bed with others Car seat Sofa or chair
8. Do you currently have a full size crib in the home? No Yes, please explain. _____
9. Do you currently have a portable crib in the home? No Yes, please explain. _____
10. How have you tried to obtain a crib? _____
11. Do you have health insurance or Medicaid? Yes No
12. Financial Eligibility for program: WIC recipient Medicaid 185% of poverty or less
13. Where did you hear about the Safe Cribs for Missouri program? (Check all that apply) WIC
 County Health Department Health Center Family/Relative Friend(s)
 Media/News/Radio/Internet Flyers/Brochures/Posters Other, please explain. _____

AGREEMENT FOR REFERRAL

I agree to allow _____ County Local Public Health Agency to provide my referral to the Missouri Department of Health and Senior Services, Safe Cribs for Missouri program to obtain a portable crib for my baby. I agree to a home visit 4 to 6 weeks after my baby is born or after I receive the crib. I agree to participate in two Safe Sleep education sessions with at least one being in my home. I am unable to afford a crib without the assistance of this program and have no other place to obtain one.

Client's Signature _____ Date _____

All Cribs will be shipped to the LPHA	
Client's Name: (please print)	
Referring Agency:	
Contact:	Phone ()
Email:	