



Safe Cribs for Missouri Program REFERRAL COLLECTION TOOL

This form can be used to collect client information that will be entered into the electronic database.

Referral Date: _____

Date Referral entered: _____

Eligibility

1. Are you a Missouri Resident? Yes No
2. Financial Eligibility for the program:
 WIC recipient Medicaid
 185 percent of poverty or less Medicaid Plan, select one.
 None of the above United Healthcare Community Plan
 Has the client used the Baby Item Benefit
 Home State Health
 Healthy Blue
 Fee-for-Service or "Straight Medicaid"
3. Does the client have a full-size crib in the home available for this baby to sleep alone? Yes No
If yes, please explain the need for an additional crib: _____
4. Does the client currently have a portable crib in the home? Yes No
If yes, please explain: _____
5. Does the client meet the residency and income eligibility requirements, and have demonstrated the need for a crib? Yes No
If yes, please proceed with the referral.
6. Does the agency have a signed copy of the agreement for the referral form? Yes No
The referring agency shall retain a copy of this form for three years.

Client Information

7. Client's First Name _____ Last Name _____ Maiden Name _____
8. Client's Date of Birth: _____
9. Relationship to Child: Mother Father Grandparent Foster parent Other
10. Address _____
Street _____ City _____ State _____ Zip _____
11. County of residence _____ Phone number (_____) _____
12. Ethnicity: Hispanic or Latino Not Hispanic or Latino
13. Race: (Check all that apply)

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Black/African American	Subcategories:	Subcategories:
<input type="checkbox"/> White	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Don't Know/Not sure	<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: (please specify) _____	<input type="checkbox"/> Korean	<input type="checkbox"/> Other: (please specify) _____
	<input type="checkbox"/> Vietnamese	
	<input type="checkbox"/> Other: (please specify)	
14. 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. _____
15. What type of health insurance do you have?

- Private Health Insurance
(paid for by you, someone else, or through work)
- TRICARE or other military health care
- None (Without Health Insurance/Uninsured)

- Medicaid (MO HealthNet, Healthy Blue, Home State Health, or United Health Care Community Plan)
- Other: _____

Client's Health History

16. Have you used any tobacco products, including cigarettes, e-cigarettes, or chewing tobacco, in the past 3 months? Yes
 No
17. Have you had any alcoholic drinks in the past 3 months? Yes No
18. Have you used any drugs not prescribed by a health care provider in the past 3 months? Yes
19. Was prenatal care received during this pregnancy? Yes No
20. Has the baby already been born? No, the mother is still pregnant Yes, the baby has been born
If No: Gestational Age (In Weeks) _____ Due Date _____
Type of pregnancy: Singleton Twins Triplets Quadruplets or more
If Yes: Number of births this pregnancy: One child Twins Triplets Quadruplets or more

Infant(s) Information

21. Baby's Date of Birth _____ Baby's full name _____ Baby's Gender: _____
Baby's full name _____ Baby's Gender: _____
Baby's full name _____ Baby's Gender: _____
Baby's full name _____ Baby's Gender: _____
22. Baby's Ethnicity: Hispanic or Latino Not Hispanic or Latino
23. Baby's Race: (Check all that apply)

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Black/African American	Subcategories:	Subcategories:
<input type="checkbox"/> White	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Don't Know/Not sure	<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: (please specify) _____	<input type="checkbox"/> Korean	<input type="checkbox"/> Other: (please specify) _____
	<input type="checkbox"/> Vietnamese	
	<input type="checkbox"/> Other: (please specify)	

Infant Sleep Information

24. Number of Cribs Requested (Only one crib per baby): _____
If not requesting a crib, please explain: _____
If requesting more than one crib, please explain: _____
25. If you do not get a crib from the Safe Cribs for Missouri Program, what are the sleeping arrangements for their baby?
 In a crib, portable crib, or bassinet On a twin or larger mattress or bed On a couch, sofa, or armchair
 In an infant car seat In a swing, rocker, or other inclined sleeper In an in-bed sleeper
 In a baby board or cradleboard Other: _____
26. 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 the client's bed with others In bed with others
 Car seat Sofa or chair

Referral Source

27. How did you hear about the Safe Cribs for Missouri program? (Check all that apply)

<input type="checkbox"/> County Health Department	<input type="checkbox"/> Health Center	<input type="checkbox"/> Family/Relative	<input type="checkbox"/> WIC
<input type="checkbox"/> Media/News/Radio/Internet	<input type="checkbox"/> Flyers/Brochures/Posters	<input type="checkbox"/> Other, please explain. _____	<input type="checkbox"/> Friend(s)