

CRIBS FOR KIDS REFERRAL FORM

Once completed, this form can be saved and attached in an e-mail to CDRC@delaware.gov. Your request will be processed within two business days. Thank you.

Referral Criteria: Check all that apply

- Baby is due within about six weeks
 Baby is less than twelve months of age
 Parents do not own an appropriate crib and are unable to purchase one
 Other, describe _____

Mother's Information

Name of mother/guardian: _____ Mother's DOB: _____

Mother's address: _____

Mother's e-mail: _____

Home phone: _____ Cell phone: _____

Other relevant maternal information (e.g. Spanish-speaking, drug use, monitored by DFS):

Race (check all that apply): Asian Black White Other

Ethnicity: Hispanic Non-Hispanic

Is there smoking in the home? Yes No. If yes, check: Mother Other: _____

Will baby be in daycare? Yes No

If Yes, check: relatives/friends center-based home-based

Mother's level of education: Last grade completed: _____ and currently in school? _____

Baby's name: _____ Baby's gender: Male Female

Baby's due date: _____ Baby's DOB: _____

Baby's Condition

- Full-term Healthy Health Issues Baby will be home on apnea monitor
 Other _____

Mothers Health Insurance: Medicaid Private None

If Medicaid, please specify: DCPI Unison DSP

MCI# if available: _____

Baby's Health Insurance: Medicaid Private None

If Medicaid, please specify: DCPI Unison DSP

MCI# if available: _____

Referring Agency Information

Date of Referral: _____ Referring Agency: _____

Referring Contract Person: _____

Phone number: _____ E-mail: _____

Other Referrals Made for Mother/Baby:

- NFP Healthy Families DFS Other: _____



Cribs for Kids[®]
Helping every baby sleep safer