



**Community Services For Children Inc.**  
**Prenatal to Five**  
**Referral Form**  
 1520 Hanover Avenue  
 Allentown, PA 18109

610-437-6000, ext. 2354 ♦ Fax 610-437-6500



**Type of Referral:**

**Early Head Start**

(Home visiting program for expectant parents families with infants to 36 months old)  
 Allentown, Bethlehem only

**Preschool Head Start or Pre-K Counts**

(Children must be at least three years old by the public school district cut off date)

**Referred Child:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:** F \_\_\_ M \_\_\_

**Child's Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Alternate Phone #:** \_\_\_\_\_

**Primary Language:** \_\_\_\_\_

**Anyone in household pregnant?** Yes \_\_\_ No \_\_\_ **Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Parent Guardian:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
 (Reside with child) (Required)

**Parent Guardian:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
 (Reside with child) (Required)

**Reason for Referral (Special Needs or Concerns):** \_\_\_\_\_ **Family Size**  
 \_\_\_\_\_ **Number of Adults** \_\_\_\_\_  
 \_\_\_\_\_ **Number of Children** \_\_\_\_\_

**Referral Agency:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Documents Needed to Complete Application:**

- Verification of Date of Birth (Birth Certificate or Hospital Record of Birth).
- Verification of your family's yearly income (pay stubs, statement from Welfare, Social Security, child support, unemployment).

*\*Please email, fax, or send copies by mail\**