Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

WORKFIRST - PUBLIC HEALTH
CHILDREN WITH SPECIAL NEEDS INITIATIVE

PUBLIC HEALTH NURSE (PHN) REFERRAL

DATE OF REFERRAL

☐ **Initial** ☐ **Re-evaluation**

PARENT/GUARDIAN'S LAST NAME FIRST NAME MIDDLE INITIAL	JAS IDENTIFICATION NUMBER	TELEPHONE NUMBER (WITH AREA CODE)
CHILD'S NAME	BIRTHDATE	CHILD'S SOCIAL SECURITY NUMBER
STREET AND MAILING ADDRESS	CITY COUNTY	ZIP CODE
REFERRED BY (CASE MANAGER/SOCIAL WORKER):	COMMUNITY SERVICES OFFICE (CSO)	TELEPHONE NUMBER (WITH AREA CODE)
MAILING ADDRESS	CITY	ZIP CODE

Reason parent/guardian indicated he/she is unable to participate in WorkFirst activities and why evaluation is being requested:

Is the child receiving other Department of Social and Health Services (DSHS) services? ☐ Yes ☐ No ☐ Unknown
If yes, check appropriate box: ☐ Division of Developmental Disabilities ☐ Division of Child and Family Services ☐ Other

Is the child receiving services from another agency? ☐ Yes ☐ No If yes, complete the following:	OTHER AGENCY'S NAME
OTHER AGENCY'S CONTACT PERSON (PLEASE PRINT)	TELEPHONE NUMBER (WITH AREA CODE)
ADDRESS	ZIP CODE

Other additional information that may be helpful to know prior to making home visit:

Interpreter Required: ☐ Yes ☐ No If yes, what language: _____

DSHS CASE MANAGER/SOCIAL WORKER SIGNATURE DATE	TELEPHONE NUMBER (WITH AREA CODE)
PRINT CASE MANAGER/SOCIAL WORKER'S NAME	FAX NUMBER (WITH AREA CODE) EMAIL ADDRESS

Please contact Case Manager/Social Worker prior to home visit: ☐ Yes ☐ No

NOTE: INSTRUCTIONS ON REVERSE SIDE.

INSTRUCTIONS FOR COMPLETING THE
PUBLIC HEALTH NURSE (PHN) REFERRAL, DSHS 10-256(x)

Enter the date of the referral and check the appropriate box: Initial or Re-evaluation.

Complete participant demographic information.

Complete WorkFirst referral source information.

Describe reasons participant indicated that s/he could not participate in WorkFirst activities and why the child is being referred to the Public Health Nurse.

Ask the participant if the child is receiving other DSHS services from another division such as Developmental Disabilities or Child Protective Services. If so, include name of other DSHS Case Manager or Social Worker.

Ask if the child is receiving services from another community social service agency such as Head Start, Infant, Toddler, Early Intervention Program (ITEIP), etc. If so, include name of person from the other agency.

Include any additional information that may be helpful.

Indicate if an interpreter is required and, if yes, indicate language.

Check appropriate box if you wish the Public Health Nurse to contact you prior to the home visit.

Fax PHN Referral, DSHS 10-256(X), to the local Public Health Department.