PROJECT SAFE SLEEP

Referral Form

Please Fax to 607-337-1709 (Phone 607-337-1660)
Or return to Chenango County Public Health 5 Court Street Norwich NY 13815

1. **Parent Name:_____**

   Address:_____

   Phone:_____

   Applicants must be a Chenango County Resident? Yes____ No____

2. **Age of child the crib will be used for _____** Must be under age 2**
   Name of Child _____ Must be born or due soon**

3. **Financial Eligibility:**
   Is the child on any of the following services currently? Yes___ No___

- Automatically eligible if the **person** receives: WIC, Medicaid or Head Start services
- Automatically eligible if the **family** receives: Food Stamps or Free/reduced school lunches
- **In this case, no need to enter the family's income***

Income Limits

Household size	Annual	Monthly	
1	$21,978	$1,832	
2	$29,637	$2,470	
3	$37,296	$3,108	
4	$44,955	$3,747	
5	$52,614	$4,385	
6	$60,273	$5,023	
7	$67,951	$5,663	
8	$75,647	$6,304	

Number of persons in family of (living together in same household) _____
***Income: _____**

4. **Referring person/agency: _____**
5. **Signature of Referring Person_____**
6. **Date _____**

_ _ _ _ _ _ _ _ _ _ _Health Department Personnel Only_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

7. **Eligible: Yes_____ No_____**
8. **Referred to _____ for pick up**
9. **Health Department Personnel Signature_____**
10. **Educational Session Completion Date _____**
11. **Follow up Phone Call Date _____**