Calhoun County Infant Safe Sleep Program
Pack-n-Play Referral Form

Date _____

Name of caller_____ **Phone(s)**_____

Name of mother (if not the same as person calling) _____

Address_____

City_____**State**_____**ZipCode**_____

Mother's Date of Birth_____**Infant's Date of Birth/Due Date**_____

OB/Prenatal Care Provider/Physician_____**# Dependents at Home**_____

How did you hear about the program?_____

Have you previously received a PNP from the program? _____**Yes** _____**No**

Statement of Need_____

Client of WIC/Medicaid _____**Yes** **No** **Race/Ethnicity**

Are you receiving home visits?

___Yes Client of **____ Nurse Family Partnership**
____Cradle Connections (MIHP)
___No **____Twenty Hands (MIHP)**

Can we share this information with participating agencies? _____**Yes** _____**No**

Referring Agency_____**211 Call Specialist**_____

Educator _____ **Date of education** _____

Recipient Agreement

I understand that should my application be approved and I receive a crib:

1. This crib/pack-n-play may not be sold or returned to the store.
2. When this crib/pack-n-play is no longer of use, I may pass it on to someone in need.
3. Except in the case of a multiples birth, only one crib/pack-n-play is given per lifetime of mother.
4. All contributing agencies are held harmless and indemnified in consideration for the provision of a crib/pack-n-play.

I have been instructed in proper use and set up of the pack-n-play and have received training and information about infant safe sleep.
All of the information on this application is true to the best of my knowledge. In addition, I have read and understand the above statements and conditions and agree to them.

Signed_____**Date**_____

211 PLEASE EMAIL COMPLETE FORM TO: Andrea Morrison at amorrison@calhouncountymi.gov

Educators: PLEASE EMAIL COMPLETED FORM TO: Andrea Morrison at amorrison@calhouncountymi.gov or FAX COMPLETED FORM to (269) 969-6488