EUP Great Parents, Great Start Referral

The Great Parents, Great Start Program is a parent involvement and education program for families with children from birth to age five. This program provides parents with methods to enhance parent-child interactions, learning opportunities, information to access community services, developmental screenings and much more. If you are interested in the Great Parents/Great Start program, please fill out this referral form.

NOTE: To avoid duplication of efforts, children and families receiving Early Head Start, Head Start, or parenting education are not eligible for Great Parents/Great Start.

PARENT INFORMATION

Mother Name:_____
First & Last

Address:_____
Street Address

_____
City, State, Zip

Native Language: _____

Home Phone: _____Cell:_____

Email: _____

Father Name:_____
First & Last

Address:_____
Street Address

_____
City, State, Zip

Native Language: _____

Home Phone: _____Cell:_____

Email: _____

CHILD INFORMATION

Name:_____

Date of Birth:_____

Gender: M____ F____

PREFERRED APPOINTMENT TIME

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Afternoon ☐ Early Evening

ELIGIBILITY QUESTIONS

Does your child have a diagnosed disability?

No Yes, please describe:_____

Does or has your child received services through Early On? No Yes

Is your child enrolled in Early Head Start? No Yes

Do you suspect your child to have a disability or behavior problem?

No Yes, please describe: _____

Child's behavior prevented participation in other group settings: OR child was referred for counseling or behavior evaluation. No Yes

A parent or guardian cannot read (illiteracy) or has low educational attainment. No Yes

English is not the primary language in the home. No Yes

Child OR sibling has been abused or neglected OR family member OR someone in the home abuses alcohol, prescription medication, or non-prescription drugs. No Yes

Child has chronic illness like asthma, allergies, frequent ear infections, OR lead poisoning; OR prenatal exposure to drugs, alcohol, or nicotine; OR lives in unsafe or crowded housing; OR unsafe neighborhood; or lack access to critical resources.

No Yes, please describe:_____

Sibling has chronic illness, severe behavior problem, OR other issue that negatively affects the child/family. No Yes

Loss of parent due to death, divorce/separation, incarceration, chronic illness, OR loss of sibling due to death; OR parent is a single parent; OR a grandparent is raising the child. No Yes

Child has a parent with a long term absence for military service or employment. No Yes

Please list any additional comments or concerns for consideration:

_____

_____

I certify that the above information is true and accurate. I also understand that the information contained will be held in confidence and used to determine eligibility.

Parent Signature: _____ Date: _____

Please return completed form to:

EUPISD (Early Childhood Programs) – 315 Armory Place – Sault Ste. Marie, 49783

Fax: (906) 632-1125. Online referrals can completed at www.eupkids.com