Family Navigator Service Request for Providers

PROGRAM INFORMATION

Contact Name: ______________________________ Position: ______________

Facility Name: ______________________________ MPI#: ______________

Facility Address: ______________________________

City: Philadelphia State: PA ZIP: ______________

Phone: ____________ Fax: ____________ Email: ____________

Hours/Days/Months of Operation: ______________________________

ECMH Consultant (if applicable): ______________________________

Type of facility: ❑ Center ❑ Family Child Care ❑ Group

Assigned HUB: ❑PHMC ❑UAC ❑SDP ❑1199c

CHILD/FAMILY INFORMATION

Child's Name: ______________________ Age: ______ Birthday: __________

Parent(s)/Guardian(s) Name(s): ______________________________

Home Address: ______________________________

Phone Number: ________________ Email Address: ________________

Best Day and Time to Contact:

- ❑ Monday Morning
- ❑ Tuesday Afternoon
- ❑ Wednesday Evening
- ❑ Thursday
- ❑ Friday

Facility Name: ______________________________ MPI#:____________________________

REQUESTED AREA(S) OF SERVICE: (Check all that apply)

	Please describe areas of concern:
❑ Medical Assistance Support ❑ Private Insurance Support ❑ Referrals to Preschool E/I ❑ Referrals to Behavioral Support ❑ IEP Meeting ❑ Other, specify ______________________	
Referrals to Other Community Resources ❑ LIHEAP ❑ Housing Resources ❑ Tenant Assistance ❑ Food Assistance ❑ Parent to Parent Support ❑ Other, specify ______________________	

Please describe in detail the support requested for the family:

SIGNATURES:

Facility Director (signature)	Printed Name	Date
ECMH Consultant (signature)	Printed Name	Date
Hub Representative (signature)	Printed Name	Date
Other (signature)	Printed Name	Date

Office Use Only: Request Complete on ___ /___ /___ ECMH Consultant: ____________________________________ Email: _________________	**Email**: zvelez@phmc.org Or **Mail**: Zaira Velez, Quality Assurance Coordinator PHLpreK at PHMC Center Square East 1500 Market Street LM500 Philadelphia, PA 19102

Family Navigator Request Instructions

The Family Navigator support is an intensive one-on-one service provided to a PHLpreK child and his/her family to help them navigate the referral to outside resources the child and family may need. This request for service can be requested by the child's ECMH Consultant or the child's PHLpreK provider.

Please fill in all parts of this request completely as described below:

***PROGRAM INFORMATION* - (Please print all information using black or blue ink)**

- ***Date:*** *Identify the date this request is submitted.*
- ***Contact Name:*** *Provide the name, title, and telephone number of the person who should be called if there are any questions about the request.*
- ***Position:*** *Specify the position (e.g., director, owner/CEO) of the person named as contact person.*
- ***MPI#:*** *Indicate the number as it appears on the facility's Department of Public Welfare Certificate of Compliance.*
- ***Facility Name:*** *Use the name of the facility as it appears on your Department of Public Welfare Certificate of Compliance. Do not use shorthand or a nickname.*
- ***Facility Address, City, State, ZIP, and County:*** *Indicate the address of the facility as it appears on your Department of Public Welfare Certificate of Compliance.*
- ***Hours and Months of Operation:*** *Specify the hours the program is open and the months the program is in operation.*
- ***ECMH Consultant:*** *Specify the name of the ECMH Consultant assigned to the PHLpreK provider and child.*
- ***Type of Facility:*** *Check-off whether the program is childcare center, group or a family day care home.*
- ***Assigned HUB:*** *Check-off which HUB the program is assigned to.*
- ***Child's Name:*** *The name of the child the referral is being requested for.*
- ***Parent(s)/Guardian(s) Name:*** *The name of the adult responsible for the child and the child's well-being.*
- ***Home Address:*** *The address of the home for the family the Family Navigator will be providing service.*
- ***Phone Number:*** *The direct number the Family Navigator will use to directly contact the Parent(s)/Guardian(s).*
- ***Email Address:*** *The email address the Family Navigator can use to directly contact the Parent(s)/Guardian(s).*

REQUESTED AREAS OF SERVICE

Check-off any of the area(s) of service you request. Provide a brief description explaining how you feel technical assistance will benefit the child the request is being made for.

SIGNATURES

All requests must be signed only by the person requesting the service. This could be either the PHLpreK provider, ECMH Consultant or Hub representative. The form does not need each one of the signatures to be processed.

RETURN COMPLETED REQUEST FORM.

Email: zvelez@phmc.org

Or **Mail**: Zaira Velez, Quality Assurance Coordinator
PHLpreK at PHMC
Center Square East
1500 Market Street LM500