



# BabyNet

South Carolina's Early Intervention System

## BabyNet Referral

Primary referral sources, including hospitals, physicians, health care providers, social service agencies, day care providers, therapists, etc., are required to refer a child who may benefit from early intervention services to BabyNet within two working days after identification (34 CFR Sec. 303.321). The Child Abuse and Prevention Treatment Act (CAPTA) (P.L. 108-36) also requires the South Carolina Department of Social Services to refer infants and toddlers birth to three, with indicated abuse or neglect and those affected by substance abuse to the BabyNet System. Once referred, BabyNet will ask the parent(s)/guardian for consent before determining eligibility. Fields with an asterisk (\*) below are required for all referrals. Shaded fields with (DSS) are required for DSS referrals. Additional information is helpful, but if not available, will not delay the referral.

### 1. CHILD INFORMATION

Referral Date:	*Child's Last Name:	*Child's First Name:	MI:	SSN:
*DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	*Address:		
*City:	*State:	*Zip	County:	
Medicaid #:	BabyNet #:	Other Insurance Information:		

### 2. PARENT/FOSTER PARENT INFORMATION (USE FOSTER PARENT IF IN FOSTER CARE)

*Parent(s)/Guardian:	Relationship:	* Home Phone if Available ( )
Work Phone: ( )	Other Phone: ( )	E-mail Address:
Best Way to Contact Parent?		
Primary Language/Mode of Communication	* Interpreter Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	

### 3. REASON FOR REFERRAL

Presenting Concerns: Referral of child birth to three for (check one):

<input type="checkbox"/>	Indicated child maltreatment (DSS)
<input type="checkbox"/>	Identified as affected by illegal substance abuse, or withdrawals for prenatal drug exposure (DSS)
<input type="checkbox"/>	Developmental delay or a condition associated with a high probability of developmental delay. Please list any medical diagnosis:
	List developmental delay or condition, (i.e. diagnosis):

Is the child currently in the Hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
DSS: Worker Safety/Security Precautions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

**List recommended worker safety precautions and any additional referral information:**

### 4. REFERRAL SOURCE

Name:	Title/Agency		
Address:	City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	E-mail Address:	
If DSS referral, please specify type:			
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Pre-Adoption	<input type="checkbox"/> Managed Treatment Services

### 5. BABYNET REFERRAL CONTACT INFORMATION

Local BabyNet System Point of Entry Office	BabyNet Referral Care Line
Phone: ( )	Phone: (800) 868-0404
Fax: ( )	Fax: (803) 898-0896

**INSTRUCTIONS**  
**BabyNet Referral Form for DSS and Other Entities**  
**SCFS/BN023 rev Jan 2010**

Form is used when referring a child from DSS or other entity to the BabyNet System.

**\* (Required)**

**1. CHILD INFORMATION:**

- **Referral Date:** \* Date referral form is completed.
- **Child's Last Name:** \* Enter legal last name of BabyNet eligible child.
- **Child's First Name:** \* Enter the first name of BabyNet eligible child. Do not use nicknames.
- **MI:** Enter child's middle initial.
- **SSN:** Enter child's Social Security Number.
- **DOB:** \* Enter child's date of birth.
- **Gender:** Check box indicating child's sex.
- **Address:** \* List address where child resides.
- **City:** \* List city for address.
- **State:** \* Enter state for address.
- **Zip:** \* Enter Zip code for address.
- **County:** Enter County where child resides.
- **Medicaid #:** Enter the child's Medicaid number.
- **BabyNet #:** Enter the child's BabyNet number.
- **Other Insurance Information:** List the name of any other type insurance the child has.
- **School District:** Enter the school district the child would attend.

**2. PARENT/FOSTER PARENT INFORMATION (USE FOSTER PARENT IF IN FOSTER CARE):**

- **Parent/Guardian:** \* Enter the parent(s)/guardians full name.
- **Relationship:** Enter parent's relationship to child (i.e. foster parent, biological parent, adoptive, surrogate).
- **Home Phone:** \* If available: Enter parents/foster parent's home phone number, if applicable.
- **Work Phone:** Enter parent's/foster parent's work phone number, if applicable.
- **Other Phone:** Enter alternative contact numbers.
- **E-mail Address:** Enter the parent's e-mail address if available.
- **Best Way to Contact Parent:** Enter best way to contact parent/foster parent.
- **Primary Language/mode of Communication:** Enter primary language of parent/foster parent.
- **Interpreter Needed:** \* Check yes if an interpreter is needed or no if an interpreter is not needed.

**3. REASON FOR REFERRAL**

- **Presenting Concerns:** Check the appropriate box to indicate if child was referred for:  
Indicated child maltreatment affected by illegal substance abuse or withdrawals for prenatal drug exposure or Developmental delay or a condition associated with a high probability of developmental delay. If a condition associated with a high probability of developmental delay, please list known medical diagnosis and specify condition.
- **List developmental delay or condition:** (i.e., diagnosis).
- **Is the Child Currently in the Hospital:** Select Yes, No or Unknown.
- **Worker Safety/Security Precautions:** Select Yes, No or Unknown.
- **Specify Above:** List any worker safety or security precautions that might exist.

**4. REFERRAL SOURCE/DSS CASEWORKER**

- **Name/Title/Profession:** Enter name/title/profession of worker making referral.
- **Agency:** Enter name of DSS agency.
- **Address:** List address for DSS agency.
- **City:** List city for address.
- **State:** Enter state for address.
- **Zip:** Enter zip code for address.
- **Phone:** Enter phone number of Caseworker source.
- **Fax:** Enter referral source's fax number.
- **Email Address:** Enter referral source's email address.
- **Check appropriate DSS Caseworker Category:** CPS, Foster, Pre-Adoption, MTS.

**5. BABYNET CONTACT INFORMATION – Information to be completed by local SPOE office.**

- **Local BabyNet System Point of Entry:** Enter county/name of SPOE office.
- **Local BabyNet Phone:** List the phone number for the local BabyNet Office.
- **Fax:** List the fax number for the local BabyNet Office.