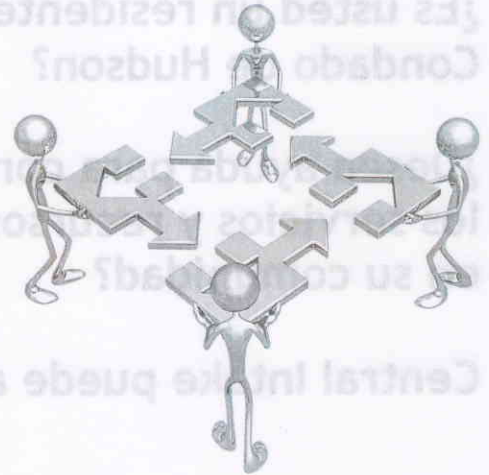


Hudson County Central Intake

Are you a Hudson County Resident?

Would you like help connecting to the available services and resources in your community?

Central Intake can help!



Central Intake is here to assist Hudson County Residents with their needs by connecting them to **FREE and **AFFORDABLE** resources. These include, but are not limited to:**

- **Pregnant and New Mom Home Visitation Programs**
- **Free Pregnancy Testing**
- **Childcare**
- **Reproductive Planning**
- **Family Counseling**
- **Domestic Violence**
- **Health Care Services**
- **Affordable Care Act**
- **Substance Abuse Treatment**
- **Food/Nutrition Assistance**
- **Food Pantries and Shelters**

For more information, call 201-876-8900 x 221



65-67 Ruby Brown Terrace, Jersey City, NJ 07305

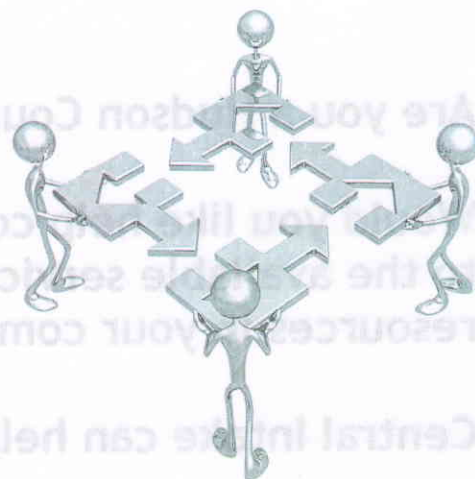
All of our services are free and provided by Central Intake, a program from the Improving Pregnancy Outcomes Initiative, funded by the NJ Department of Health.

Hudson County Central Intake

¿Es usted un residente del Condado de Hudson?

¿Desea ayuda para conectarse a los servicios y recursos disponibles en su comunidad?

Central Intake puede ayudar!



Central Intake está aquí para ayudar a los residentes del Condado de Hudson con sus necesidades. Podemos ayudarle a conectarse a servicios y recursos gratis o baratos.

Estos incluyen, pero no se limitan a:

- Servicios de Visitas al Hogar para Mujeres Embarazadas y Nuevas Mamás
- Pruebas de Embarazo
- Guarderías para Niños
- Planificación Reproductiva
- Consejería Familiar
- Violencia Doméstica
- Servicios de Salud
- Ley del Cuidado de Salud a Bajo Precio
- Tratamiento de Abuso de Sustancias
- Asistencia Alimenticia y Nutricional
- Despensas de Alimentos y Refugios

Para más información, llame al 201-876-8900 x 221



Partnership for
Maternal &
Child Health
OF NORTHERN NEW JERSEY

65-67 Ruby Brown Terrace, Jersey City, NJ 07305

Todos nuestros servicios son gratuitos y proporcionados por Central Intake, un programa de la Iniciativa Para Mejorar Los Resultados de Embarazos, financiado por el Departamento de Salud de Nueva Jersey.

The Partnership for Maternal and Child Health of Northern NJ
Hudson County Central Intake
Referral Form

PLEASE PRINT CLEARLY

* REQUIRED

* Date of Referral

Participant Information		____ - ____ - ____												
* Last Name _____	* First Name _____	* Date of Birth _____												
Street Address _____		City _____												
* Zip Code _____	* County _____	Participant ID _____												
Referral Agency Information														
* Referral Agency Name _____														
Name of Person making the Referral _____		Phone _____												
Outreach Type <input type="radio"/> Agency <input type="radio"/> Self <input type="radio"/> Door to Door <input type="radio"/> Event (specify) _____ <input type="radio"/> Other _____														
* Primary Language <small>(Choose one)</small> <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____	* Race <small>(Choose one)</small> <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Native American	* Ethnicity Hispanic <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Multi-Racial <input type="radio"/> Alaskan/Pacific Islander <input type="radio"/> Other _____												
* Health Insurance <small>(Select all that apply)</small> <input type="radio"/> Medicaid PE <input type="radio"/> Commercial/Private <input type="radio"/> NJ Family Care <input type="radio"/> Uninsured/Self Pay <input type="radio"/> Medicare														
Participant Contact Information		Household Information												
* Primary Phone _____	* Preferred Contact Method <small>(Choose one)</small> <input type="radio"/> Primary Phone <input type="radio"/> Email <input type="radio"/> Alternate Phone <input type="radio"/> Text	How many children live in your household? <small>(Write the number of children for each age group.)</small> <table style="width: 100%;"><tr><td>____ 0-30 days</td><td>____ 6-8 years</td></tr><tr><td>____ 1-12 months</td><td>____ 9-14 years</td></tr><tr><td>____ 1-2 years</td><td>____ 15-17 years</td></tr><tr><td>____ 3-5 years</td><td>____ 18-19 years</td></tr></table>	____ 0-30 days	____ 6-8 years	____ 1-12 months	____ 9-14 years	____ 1-2 years	____ 15-17 years	____ 3-5 years	____ 18-19 years				
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____ 1-12 months	____ 9-14 years													
____ 1-2 years	____ 15-17 years													
____ 3-5 years	____ 18-19 years													
Alternate Phone _____	* At which phone number can we text you? <input type="radio"/> Primary <input type="radio"/> None <input type="radio"/> Alternate													
Email Address _____														
Participant Is... (Choose One)														
<input type="radio"/> Preconceptional Woman	<input type="radio"/> Pregnant Woman	<input type="radio"/> Interconceptional Woman												
<input type="radio"/> Male														
Has no children and has never been pregnant	* First Time Parent? <input type="radio"/> Yes <input type="radio"/> No * In Prenatal Care? <input type="radio"/> Yes <input type="radio"/> No * Due Date ____ - ____ - ____	Previously pregnant and not currently pregnant. <small>(Does not matter if woman has children.)</small> * Age(s) of children needing services 1. ____ 2. ____ 3. ____ <input type="radio"/> NA												
* Are you a Parent? <input type="radio"/> Yes <input type="radio"/> No * First Time Parent? <input type="radio"/> Yes <input type="radio"/> No Does your child live w/ you? <input type="radio"/> Yes <input type="radio"/> No														
Did you or a family member have any of these issues when you tried to get healthcare in the past? (Select all that apply)														
<table style="width: 100%;"><tr><td><input type="checkbox"/> No Insurance for myself</td><td><input type="checkbox"/> No transportation</td></tr><tr><td><input type="checkbox"/> No Insurance for my children</td><td><input type="checkbox"/> No childcare</td></tr><tr><td><input type="checkbox"/> No money for co-pays</td><td><input type="checkbox"/> Could not miss work</td></tr><tr><td><input type="checkbox"/> Could not find a doctor</td><td><input type="checkbox"/> No time</td></tr><tr><td><input type="checkbox"/> Could not get an appointment</td><td><input type="checkbox"/> Staff was rude</td></tr><tr><td><input type="checkbox"/> Did not think going to the doctor was important</td><td><input type="checkbox"/> Other _____</td></tr></table>			<input type="checkbox"/> No Insurance for myself	<input type="checkbox"/> No transportation	<input type="checkbox"/> No Insurance for my children	<input type="checkbox"/> No childcare	<input type="checkbox"/> No money for co-pays	<input type="checkbox"/> Could not miss work	<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time	<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude	<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____
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<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude													
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____													

*** Participant Consent**

I agree to provide the information above and to have it forwarded as a referral to available service agencies in my community. I agree to be contacted, and for Improving Pregnancy Outcomes staff to follow-up with me or the agency to which I was referred to support my care.

☐ Oral consent given

Signature of Participant _____

Sign _____ Print _____

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Please FAX form to 201-204-4056 or E-MAIL to dpicon@partnershipmch.org

Program Use Only

Date Pregnancy Test Given

____ - ____ - ____

Pregnancy Test Positive?

☐ Yes ☐ No