



KidConnections Network (KCN)/ Help Me Grow (HMG) Referral Cover Sheet

Date: _____

Number of Attachments: _____

Send To: County of Santa Clara KCN/ HMG Behavioral Health Referral Center at:

KCN.Referral@hhs.sccgov.org or Fax to: 408.947.5848

REFERRAL PARTY INFORMATION (PLEASE CLEARLY PRINT):

Referral Source Agency: _____

Full Name & Phone Number: _____

Email Address (included email for those to receive disposition of referral notification):

Attachment Checklist

- 1. KCN Referral Cover Sheet
- 2. STARTS Referral Form
- 3. ASQ-3 Summary Page (completed within 60 days of the referral)
- 4. ASQ: SE-2 Summary Page (completed within 60 days of the referral)
- 5. Other Documents (Optional)

Caregiver Request/ Comments:

CONFIDENTIAL PATIENT INFORMATION

The attached material is intended only for the use of the individual or entity to which it is addressed, and may contain information that is confidential, privileged, and exempt from disclosure under applicable law.

If you are not the intended recipient, you are notified that any use, distribution, or copying of this document is strictly prohibited.

In the event that you receive this communication in error, please notify us immediately