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: