Merced County Department of Public Health

Young Parents Program Referral Form

Phone 1-800-649-6849 Fax 209-724-4011

Date of Referral:

Referring Agency and Provider Information	
Name:	
Contact person:	Phone:
Address:	City:
Reply Requested: Yes ☐ No ☐	

Client Information		
Last Name:	First Name:	
Sex: Male ☐ Female ☐	Date of Birth:	
Address:		
City:	Zip Code:	
Phone:	Primary Language:	
Speaks English: Yes ☐ No ☐	Race:	Hispanic: Yes ☐ No ☐
Medi-Cal: Yes ☐ No ☐	If yes Medi-Cal #:	
Client Currently Pregnant: Yes ☐ No ☐	*If Pregnant EDC:*	
Client Currently Parenting: Yes ☐ No ☐	*If Client is Currently Parenting Enter Childs Information Below*	
Child's Last Name:	Childs First Name:	
Child's Date of Birth:		

Client Living Status		
☐	Client Lives Alone	
☐	With Parent	Parent Name:
☐	With Guardian	Guardian Name:
☐	With Relative	Relative Name:
Relative Relation to Client:		
☐	With Friend	Friend Name:

Client Education Status	
Client Currently Attending School: Yes ☐ No ☐	School Name:
If Yes Current Grade:	*If No Last Grade Completed:*
Additional Comments or Concerns:	

260 E 15th Street, Merced, CA 95341

Any questions please call SPHN Cheryl Assante (209) 381-1162