Adult Representation Services

HELP Program Referral Form

CONTACT INFORMATION

Date of Referral: _____

Referred by:

Name: _____ Title/Agency: _____

Phone: _____ Email: _____

Parent Information (Prospective client):

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Race: _____ Primary language: _____

Due date/DOB of child: _____ Preferred contact method: Phone

Best day/time to contact:

OB Provider

Name: _____ Clinic/Hospital: _____

Phone: _____ Email: _____

Is the family aware you are making this referral? ☐ Yes ☐ No

ELIGIBILITY QUESTIONS

1. Does the parent reside in Hennepin County?
   - ☐ Yes
   - ☐ No

2. Parent is:
   - ☐ Currently pregnant
   - ☐ Parent has at least one child under 5 in the home

3. Parent is experiencing hardships that put them at risk for child protection involvement:
   - ☐ Yes (please use the space below to provide a brief summary)

   - ☐ No

4. Does the parent have limited financial resources? (ARS will contact the parent to complete a full financial screen to ensure eligibility for HELP services)
   - ☐ Yes
   - ☐ No

Please share any additional information below:

Submit completed referral form via email or fax to:

Hennepin County Adult Representation Services
525 Portland Ave. S., Ste 1000, Minneapolis, MN 55415-1600
Main Office: 612-348-7012 | Fax: 612-543-0938
Email: ContactARS@hennepin.us
http://www.hennepin.us/ars