Reset Form

HOME VISITING REFERRAL PARTNER APPLICATION

State Form 9900364 (10-25)
INDIANA DEPARTMENT OF HEALTH

INSTRUCTIONS:

1. *If your home visiting program is interested in participating in Indiana's home visiting referral system, please complete this application and send it via email to MyHealthyBaby@health.in.gov*
2. *Once you submit this form, the My Healthy Baby project team will review your application. We may reach out with questions. Programs that meet criteria to participate in referrals from My Healthy Baby are not automatically enrolled. If your program is approved, our team will schedule time to meet with you and the community to revisit the current referral process and next steps.*

Organization Name: _____

Name of Home Visiting Progranm or Model: _____

Please list all counties served by your home visiting program:

How long has your home visiting program been operating? _____

What curriculum does your program use (if any)?

Please indicate the frequency of your home visits:

- ☐ Visits are usually weekly or biweekly with the client
- ☐ Visits are usually monthly with the client
- ☐ Visits are only when the client has a specific need
- ☐ Other: _____

Does your program serve pregnant women? _____

How long after the baby is born does your program continue to serve the family? _____

Does your program use an electronic documentation system? ☐ Yes ☐ No

If yes, what system are you using? _____

Does your program charge families for visits? ☐ Yes ☐ No

If yes, what is the fee structure?

Primary contact for your home visiting program: _____

Primary contact's email address: _____

Primary contact's telephone number (*include area code*): _____

Today's date: _____