BabyNet
South Carolina's Early Intervention System

Referral to BabyNet

FIRST STEPS
Getting children ready for school.
SOUTH CAROLINA

Primary referral sources, including hospitals, physicians health care providers, social service agencies, day care providers, therapists, etc., are required to refer a child, birth to three years of age who may benefit from early intervention services, to BabyNet within two working days after identification (34 CFR Sec.303.321). Once referred, BabyNet will ask the parent(s)/ guardian for consent before determining eligibility.

1. CHILD INFORMATION

Referral Date:	*Child's Last Name:	*Child's First Name:	MI:	SSN:
*DOB:	Gender: ☐ Female ☐ Male	*Address:		
*City:	County:	*State:	*Zip	
Medicaid #:	Other Insurance Information:		BRIDGES ID #	

2. PARENT/GUARDIAN INFORMATION (USE FOSTER PARENT IF IN FOSTER CARE)

*Parent(s)/Guardian:	Relationship:	* Home Phone if Available
Work Phone:	Other Phone:	E-mail Address:
Primary Language/Mode of Communication		* Interpreter Needed ☐Yes ☐ No

3. REASON FOR REFERRAL

Presenting Concerns: Referral of child birth to three for (check one):

	Suspected Developmental Delay List developmental Area(s) of concern: Developmental Screening completed? ☐Yes ☐No ☐Unknown Referral Source is requested to send the Developmental Screening results to the local BabyNet System Point of Entry (SPOE) Office at the time of referral
	Condition associated with a high probability of developmental delay List all medical diagnoses: Child is currently hospitalized? ☐Yes ☐No
	CAPTA Referral. The Child Abuse Prevention and Treatment Act (CAPTA P.L. 111-320) requires the South Carolina Department of Social Services to refer infants and toddlers, ages birth to three, with substantiated abuse or neglect, and those affected by substance abuse to the BabyNet Early Intervention System. ☐Substantiated child maltreatment ☐Identified as affected by illegal substance abuse or withdrawal from prenatal drug exposure Worker safety precautions recommended:

4. REFERRAL SOURCE

Name:		Title/Agency	
Address:	City:	State:	Zip:
Phone Number:	Fax Number:	E-mail Address:	

5. BABYNET REFERRAL CONTACT INFORMATION		
BABYNET DISTRICT:	**FAX:**	**CONTACT:**
ANDERSON *Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee, Saluda*	Fax: (864) 225-8121	***ATTN:*** Alyssa Bowser Phone: (864) 225-6465 abowser@scfirststeps.org
CHARLESTON ***Berkeley, Charleston, Dorchester***	Fax: (843) 740-3198	***ATTN:*** Martha Johnson Phone: (843) 740-3193 majohnson@scfirststeps.org
COLLETON ***Beaufort,*** *Colleton, Hampton,* ***Jasper***	Fax: (843) 379-7840	***ATTN:*** Jacquelyn Walker Phone: (843) 782-3404 jwalker@scfirststeps.org
HORRY *Chesterfield,* ***Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Kershaw, Lee, Marlboro, Marion, Sumter, Williamsburg***	Fax: (843) 839-5046	***ATTN:*** Angela Lassen Phone: (843) 839-5133 alassen@scfirststeps.org
RICHLAND ***Fairfield, Lexington, Newberry, Richland***	Fax: (803) 734-0236	***ATTN:*** Sheri Sandoval Phone: (803) 734-0111 ssandoval@scfirststeps.org
Aiken, Allendale Bamberg, Barnwell, Calhoun, Orangeburg	Fax: (803) 533-5953	***ATTN:*** Michelle Woodall Phone: (803) 533-5446 mwoodall@scfirststeps.org
SPARTANBURG ***Cherokee, Spartanburg, Union***	**Fax: (864) 591-8640**	***ATTN:*** **Wanda Blakely** **Phone: (864) 591-8642** wblakely@scfirststeps.org
Greenville, Pickens	Fax: (864) 331-1456	***ATTN:*** Karen McCollister Phone: (864) 331-1451 kmccollister@scfirststeps.org
YORK ***Chester, Lancaster, York***	Fax: (803) 222-6269	***ATTN:*** Devora Killian Phone: (803) 222-5360 dkillian@scfirststeps.org

SCFS/BN023 rev Jan 2010

INSTRUCTIONS
BabyNet Referral Form
SCFS/BN001 rev March 2014

Form is used when referring a child to the BabyNet Early Intervention System.
*** (Required)**

1. CHILD INFORMATION:

- **Referral Date: *** Date referral form is completed.
- **Child's Last Name: *** Enter legal last name of BabyNet eligible child.
- **Child's Firs Name: *** Enter the first name of BabyNet eligible child. Do not use nicknames.
- **MI:** Enter child's middle initial.
- **SSN:** Enter child's Social Security Number.
- **DOB**: ***** Enter child's date of birth.
- **Gender:** Check box indicating child's sex.
- **Address: *** List address where child resides.
- **City: *** List city for address.
- **State: *** Enter state for address.
- **Zip: *** Enter Zip code for address.
- **County:** Enter County where child resides.
- **Medicaid #:** Enter the child's Medicaid number.
- **BabyNet #:** Enter the child's BabyNet number.
- **Other Insurance Information:** List the name of any other type insurance the child has.
- **School District:** Enter the school district the child would attend.

2. PARENT/GUARDIAN INFORMATION (USE FOSTER PARENT IF IN FOSTER CARE):

- **Parent/Guardian: *** Enter the parent(s)/guardians full name.
- **Relationship:** Enter parent's relationship to child (i.e. foster parent, biological parent, adoptive, surrogate).
- **Home Phone: *** If available: Enter parents/foster parent's home phone number, if applicable.
- **Work Phone:** Enter parent's/foster parent's work phone number, if applicable.
- **Other Phone:** Enter alternative contact numbers.
- **E-mail Address:** Enter the parent's e-mail address if available.
- **Best Way to Contact Parent:** Enter best way to contact parent/foster parent.
- **Primary Language/mode of Communication:** Enter primary language of parent/foster parent.
- **Interpreter Needed: *** Check yes if an interpreter is needed or no if an interpreter is not needed.

3. REASON FOR REFERRAL Check one

- **Suspected Developmental Delay**
  - List developmental areas of concern
  - If developmental screening has been conducted, please attach to referral form
- **Condition associated with a high probability of developmental delay**
  - List developmental delay or condition: (i.e., diagnosis).
  - Is the Child Currently in the Hospital: Select Yes, or No
- **CAPTA Referral**
  - Check the appropriate box to indicate if child was referred for:
    - Indicated child maltreatment
    - Affected by illegal substance abuse or withdrawals for prenatal drug exposure or Developmental delay
- **Worker Safety/Security Precautions:** List any worker safety or security precautions that might exist.

4**. REFERRAL SOURCE/DSS CASEWORKER**

- **Name/Title/Profession:** Enter name/title/profession of worker making referral.
- **Agency:** Enter name of agency.
- **Address:** List address for agency.
- **City:** List city for address.
- **State:** Enter state for address.
- **Zip:** Enter zip code for address.
- **Phone:** Enter phone number.
- **Fax:** Enter referral source's fax number.
- **Email Address**: Enter referral source's email address.

5. BABYNET CONTACT INFORMATION is listed on the second page of the form