PROJECT SAFE SLEEP: Cribette Referral Application

Referring Agency Information

Name: Email:

Agency:

Agency Mailing Address:

Phone Number:

SIDS of IL prefers sending cribettes to the agency. If this is not possible, please indicate the reason here:

Family Information

Does the family receive any public assistance? (circle all that apply)

SSI LINK WIC TANF Medicaid Benefits: *Yes* *No*

Patient Information

Name of Mother: Does mom smoke? *Yes* *No*

Age of Mother (in years):

Preferred Language of Mother:

Insurance Carrier of Mother:
If Medicaid, please indicate provider (BCBS, Aetna, etc.)

Mother's Full Address:

Phone Number: Allows Text Messaging? *Yes* *No*

Additional Phone Number (if needed):

Due Date // Baby's Birthdate:

Baby's Name:

Twins ?

How many Cribettes need to be distributed to this family?

How many adults in household: Does anyone smoke in the home? *Yes* *No*

How many children in home:

Ages of children in home:

Authorization Signatures:

FOR CLIENT: I authorize the referring agency to share the above information with SIDS of IL, Inc.

× _____ (Client Signature) Date: _____

FOR REFERER: I sign off that client above is in need of a crib and does not already own a safe crib.

× _____ (Referrer Signature) Date: _____

How to submit this application: above application can be faxed to SIDS of IL, Inc. (630-541-8246) or sent via **ENCRYPTED** email to Nancy@sidsillinois.org or Lucy@sidsillinois.org . Please allow up to 3 days for follow-up to see if application has been approved. Refer to parameters page to see if family qualifies for a cribette.