Nurse-Family Partnership (NFP)
Client Referral Form

To qualify for the Nurse-Family Partnership Program, a potential client must meet the following requirements:

- **Be enrolled before the end of her 28th week of pregnancy**
- **Be a first-time mom** (no previous live births)
- **Receive Medicaid, Food Stamps (SNAP), WIC, and/or TANF**
- **Reside within El Paso County**

Today's Date:							
Please checkmark below all services client is currently receiving.							
	Medicaid		**SNAP**		**WIC**		**TANF**
Client Contact Information							
Client's Name:							
DOB:							
Expected Due Date:							
Cell Ph./Home#:							
Home Address (please include zip code)							
Mailing Address (if different from home address)							
Email:							
Alternative Contact Info							
Name of Contact:							
Relationship to Client:							
Ph. #:							
Client Signature							
By signing above, client agrees to be referred to the NFP program and disclose information regarding her pregnancy to NFP staff.							

Agency Referral Source Info
Please include your organization if applicable*
Agency:
Name:
Best Contact Ph.#:
Email:

Please call, fax, or email client referral information to:
Valerie Watters, MSN, RN, CLC, Nurse Supervisor
vwatters@umcelpaso.org
Office: 915-838-5143 Fax: 915-521-7038
Anaceli Guevara, Data Analysis Coordinator
anaceli.guevara@umcelpaso.org
Office: 915-521-7162 Fax: 915-521-7038

For NFP Use Only					
Date received:					
Assigned to NHV:					
ETO#					
28 Weeks:					
NHV Contact Attempts					
1st Call		2nd Call		3rd Call	
Date:		Date:		Date:	
	Left Msg.		Left Msg.		Left Msg.
	No Answer		No Answer		No Answer
	Bad#		Bad#		Bad#
	Refused Participation		Refused Participation		Refused Participation
Additional Notes: (Include dates)					
997-045-11 rev 10.2018					

Nurse-Family Partnership (NFP)
Client Referral Form

Para inscribir al programa del NFP, se requiere que la clienta:

- **Inscriba antes del último día de su 28 semana de embarazo**
- **Sea mamá primeriza (no tener hijos previos)**
- **Recibe Medicaid, Estampillas de comida (SNAP), WIC, y/o TANF**
- **Reside dentro el condado de El Paso**

Fecha:							
Favor de marcar todos los servicios que la clienta recibe							
	Medicaid		**SNAP**		**WIC**		**TANF**
Información de la Clienta							
Nombre:							
Fecha de Nacimiento:							
Fecha de Parto:							
Número del Celular/Casa:							
Dirección:							
Dirección de Correo: (si es diferente del hogar)							
Correo electrónico:							
Información Alternativa							
Nombre:							
Relación a la Clienta:							
Número del Celular/Casa:							
Firma de la Clienta							
Al firmar arriba, la clienta está de acuerdo en estar referida al programa de NFP y en compartir información sobre su embarazo con el personal del programa de NFP.							

Agency Referral Source Info
Please include your organization if applicable
Agency:
Name:
Best Contact Ph.#:
Email:

¡Pero lo tienes bajo control!

con una enfermera personal gratis

para darte el apoyo, los consejos y la información que necesitas como madre primeriza, embarazada de tu primer bebé.

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