



Changing Directions.  
Changing Lives.

# The HERO Project

## HElping R Restore families impacted by Opioids

Send completed referral forms to: [Nikesha.Williams@CHRIS180.org](mailto:Nikesha.Williams@CHRIS180.org)

Date of Referral: \_\_\_\_\_

### REFERRED CHILD INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Last four numbers of Social Security: \_\_\_\_\_

Insurance: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Home/Placement Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

### Eligibility Criteria (check all that apply):

- Newborn whose mother/father was/has an opioid use disorder.
- Child at risk for accidental ingestion or inhalation of toxic substances due to parental usage
- Child living with or has lived with a parent with a substance use disorder, and they are dealing with uncertainty and fear.
- Child who experienced taking over the role of family caregiver for younger siblings or for their parents with a substance use disorder
- Child who was/is removed from their homes and placed in foster or kinship care.
- A very young children exposed to toxic levels of stress that impacted their brain development.

Brief description for Referral: (specific behaviors and symptoms)

### PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: \_\_\_\_\_

Relationship to the child: \_\_\_\_\_ Contact #: \_\_\_\_\_

Additional Contact Name: \_\_\_\_\_

Relationship to the child: \_\_\_\_\_ Contact #: \_\_\_\_\_

### REFERRAL SOURCE

Referral Source Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referral number: \_\_\_\_\_ Email: \_\_\_\_\_

Thank you for your referral!  
Submission of this referral does not guarantee acceptance into the program.