igrow Central Illinois Coordinated Intake uses IRIS (Integrated Referral and Intake System) to make referrals to home visiting programs, specifically IHV or LTHV programs, in the Tazewell, Peoria and Woodford communities. If you or your organization would like more information about IRIS or how to become an IRIS partner, please reach out to the Tazewell County Health Department, tazcohth@tchd.net.

CIAT – Coordinated Intake Assessment Tool

igrow Central Illinois Coordinated Intake is the path for area caregivers to get connected with long term home visiting programs as well as family support services and other community resources. All services provided are voluntary, confidential, and free.

1. Complete as much of this form as possible. 2. Get permission to refer and mark the space below. 3. Return CIAT to coordinated intake; for Tazewell, Peoria & Woodford counties HV referrals go to (CI) igrow Central Illinois within IRIS or via email igrow@chail.org or fax 309-686-9112.

Date: _____/_____/_____ Person Completing Form: _____

Referral Source: _____ Phone: (_____) _____-_____

Email Address: _____ Fax: (_____) _____-_____

Caregiver #1 First Name: _____ Last Name: _____
if applicable – Caregiver #2 information below

Phone: (_____) _____-_____ OK to text? □ Yes □ No Additional: (_____) _____-_____

DOB: ____/_____/_____ Pronouns: □ she/her □ he/him □ they/them □ _____

Address: _____

City, State: _____ Zip Code: _____

Email address: _____

County: □ Peoria □ Tazewell □ Woodford □ Other _____ School Name/District: _____

If pregnant, EDD: ____/____/_____
□ First time caregiver *
□ Pregnant and under 21 *

1st OB appt: ____/____/_____

Number of children in the home:
□ 1 □ 2 □ 3 □ 4 □ 5 or more

Youngest child; Name, DOB
_____, ____/____/_____

Additional children; Name, DOB
_____, ____/____/_____
_____, ____/____/_____
_____, ____/____/_____
_____, ____/____/_____
_____, ____/____/_____

Race/Ethnicity: please select all that apply.
□ African
□ American Indian, Alaska Native, or Indigenous
□ Asian
□ Black
□ Caucasian
□ East Asian
□ Hispanic/Latino/Latina/Latine
□ Middle Eastern
□ Native Hawaiian/Pacific Islander
□ South Asian
□ Southeast Asian

□ Self-describe: _____
□ No response to race or ethnicity

Preferred language: _____

Languages spoken: _____

Services being received:
□ Early Intervention
□ WIC □ SNAP
□ TANF □ Foster Care
□ BBO □ FCM
□ SSI □ SSD
□ DCFS □ CCAP
□ other: _____

Health Insurance: □ None
□ Military (TriCare)
□ Public (Medicaid, Medicare, etc)
□ Private (HMO, etc)
□ other: _____

Grade level achieved: _____

Currently enrolled: □ Yes □ No
HS Graduate/GED: □ Yes □ No

Primary income for the past 12 months (select all that apply): □ employment □ other: _____

□ below $10000/year □ $10001-$39000/year □ $39001-$52000/year □ $52001-$100000+/year

Weighted Eligibility Criteria	
Household has a child with developmental delays or disabilities *	☐
Household has a history of child abuse or neglect or has had interactions with child welfare services *	☐
Unhoused/housing instability *	☐
Low income (household makes less than 50% of the FPL) *	☐
English not the primary language of caregiver	☐
History of substance abuse or needs substance abuse treatment (anyone in the household) *	☐
Tobacco use (someone in the household uses tobacco products inside the home) *	☐
Single caregiver or blended family	☐
Trauma, depression, anxiety, isolation, mental health concerns or lack of support system (anyone in the household) *	☐
Household includes individual(s) who are serving or formerly served in the US armed forces *	☐
Someone in the household has attained low student achievement or has a child with low student achievement *	☐
Vision, hearing and speech concerns of caregiver and/or child(ren)	☐
Someone other than bio parent raising the child(ren)	☐
History of high-risk pregnancy	☐
Significant health problems/chronic illness of the child(ren)	☐
No regular source of health care *	☐
	☐
	☐

* MIECHV priority populations & other high-risk factors

Caregiver #2 First Name: _____ Last Name: _____ DOB: ____/_____/_____

Pronouns: □ she/her □ he/him □ they/them □ _____ Phone: (_____) _____-_____ OK to text? □ Yes □ No

Address: _____ Zip Code: _____

Is this referral a KEEPER? □ Yes □ Enrolled □ Pending enrollment □ No □ Needs to be referred to IHV program

I agree to release the information above to be shared electronically with coordinated intake and other agencies to assist in providing connection to the most appropriate services.

Signature: _____ Date: ____/_____/_____

☐ **consent for the release of information of signee/referral to coordinated intake for documenting and sharing with any appropriate agencies for service.**