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| grow training referral |
| Michigan Department of Health and Human Services |
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| This referral form must be completed and emailed to the appropriate contractor. This information can be found at [www.fcnp.org/pridegrow-training-schedules](https://stateofmichigan.sharepoint.com/teams/insidedhhs/work/formsandpolicies/FormsLibrary/www.fcnp.org/pridegrow-training-schedules). Upon receipt of the referral, contractors will contact the client identified on this form to complete the registration process. |
| **REFERRAL IDENTIFICATION** | Date |       |
| Name(s) | Person(s) ID | Phone Number |
|       |       |       |
| Prefixes (ex. Dr., Mx., Ms., etc.) | Pronouns (ex. She/her, he/him, zi/zir, etc.) |
|       |       |
| Email Address | Referral Type |
|       | [ ]  Adoption | [ ]  Foster | [ ]  Relative |
| Home Address |
|       |
| Preferred Training County | Preferred Training Month |
|       |       |
| Preferred Method of Contact |
| [ ]  Email | [ ]  Text | [ ]  Phone Call |
| Adopt/Licensing Worker | Agency |
|       |       |
| Worker Phone Number | Worker Email Address |
|       |       |
| Referring Agency Notes |
|       |
| **For Regional Resource Team Use Only** |
| **TRAINING RECORD** |
| Client Contacts | Referral Received Date |       |
|       |
| **GROW SESSION ATTENDANCE LOG** |
| **Session** | **Completion Date** | **Trainer** |
| 1. Introduction
 |       |       |
| 1. Child Development
 |       |       |
| 1. Systems, Policies and Advocacy
 |       |       |
| 1. Attachment and Relationships
 |       |       |
| 1. Diversity and Inclusion
 |       |       |
| 1. Toxic Stress, Trauma, and Trauma-Informed Parenting
 |       |       |
| 1. Foster, Adoptive and Kinship Parent Wellbeing
 |       |       |
| 1. Mental Health and Special Needs
 |       |       |
| 1. Conclusion
 |       |       |
| 1. Panel – Adoption
 |       |       |
| 1. Panel – Foster Care
 |       |       |
| 1. Panel – Relative

  |       |       |
| 1. Prudent Parent
 |       |       |
| 1. Safe Sleep
 |       |       |
| Trainer Feedback (include observations about the prospective resource parent(s) and areas where further training is needed) |
|       |
| [ ]  No comments/concerns |
| By signing below I certify that the individual(s) listed above have participated in |       | hours of |
| GROW training. |
| Certifying Trainer Signature | Date |
|  |       |
| The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility. |
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