



We connect New Jersey families - moms, dads, newborns, teens, young adults, and grandparents - with the best health and social resources available in their local community.

Looking for programs, resources and more in your area?

Individuals and families who are interested in getting connected can fill out the form below.

How can we help?

What type of support, resources, or services are you interested in?

- Basic needs (ex. clothing, diapers, formula)
- Breastfeeding
- Child care
- Child development
- Community Health Worker (assistance connecting to services)
- Domestic violence
- Doula services
- Employment assistance
- Food assistance
- Health insurance
- Healthcare for myself or my children (ex. primary care, dentist, physical therapy)
- Home visiting (in-home parent support)
- Housing/Rental/Utility assistance
- Legal advice
- Mental health
- Prenatal and postpartum care
- Public benefits (ex. TANF/GA and SSI)
- Substance use
- Other (please specify)

Your Contact Information

First Name*

Last Name*

Street Address*

City*

Zip*

County*

-Select County- ▼

Email Address

Primary Phone*

123-555-1234

Preferred Contact Method*

Select ▼

Alternate Phone

123-555-1234

At which phone number can we text you?*

Select ▼

Demographic Information

Date of Birth*

mm/dd/yyyy

Race*

-Select Race- ▼

If other race, please specify*

Health Insurance*

NJ Family Care

Medicare

Commercial/Private

Uninsured/Self Pay

How do you identify?*

-Select- ▼

Primary Language*

-Select Language- ▼

If other language, please specify

Hispanic or Latino?*

Yes No

Parenting Information

Are you a parent?*

Yes No

Have you ever been pregnant?*

Yes No N/A

Are you currently pregnant?*

Yes No N/A

If yes, is this your first child?

Yes No

Are you a first-time parent?*

Yes No

If yes, are you currently in prenatal care?

Yes No

If yes, due date?

mm/dd/yyyy

Would you like information on support, resources, or services for any of the children living in your home?

Child 1

DOB

mm/dd/yyyy

Name

Relation

-Select Relation- ▼

Child 2

DOB

mm/dd/yyyy

Name

Relation

-Select Relation- ▼

Child 3

DOB

mm/dd/yyyy

Name

Relation

-Select Relation- ▼

Comments

Comments/Questions

Consent

I agree to have the information I provided for this initial referral shared with Connecting NJ for my county. I agree to be contacted by Connecting NJ staff, who will further assist with connecting me and/or my family to supportive services.

Submit

