DSS Referral Form for Early Intervention Services (CDSA)

(Referral must be completed and sent to Early Intervention Services **within 72 hours of Substantiation or In Need of Services Finding**)

(Please attach copy of DSS Family Strengths and Needs Assessment)

Date of DSS Referral:_____ Date of DSS Finding of "Substantiation" or "In Need of Services":_____Basis of "Substantiation" or "In Need of Services":_____

Child's Name:_____

Date of Birth:_____ Male_____ Female :_____ Race/Ethnicity:_____

Language, if other than English:_____

Address:_____

Telephone Number:_____

Referring County Department of Social Services:_____

DSS Contact Person_____Telephone:_____

Parent/Caretaker Name:_____

(If parent is not legal guardian, list who has legal custody and how they can be contacted)

Legal guardian contact information:_____

Does parent/caretaker have any known or suspected physical or mental health problems? _____

Is parent/caretaker involved with any other agencies or medical providers? _____

Any prior assessments for medical and/or developmental needs? By whom? _____

Does child have any diagnosed or suspected developmental delays or other special needs? _____

Child's primary medical provider. (Please provide telephone number and/or address)_____

Is child seen by any other social service agency or medical provider? _____

Child has: Medicaid/HealthChoice? (Y/N)_____ Other Insurance? (Y/N)___Other? _____

(see reverse of form)

Has family been informed about CDSA referral?_____ (Must be done prior to referral)

Any other information that would help Child Developmental Service Agency (CDSA) understand this family _____

Directions to Home:_____