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":________________
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____

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:____