NYC EARLY INTERVENTION PROGRAM

CLOSURE FORM

*(To be used by the service coordinator only when ALL EI services terminate, the child ages out, or when child is found ineligible)**

Child's Name: _____
(Last) (First) Middle

EI ID #: _____ DOB: _____/_____/_____

Effective Date of Closure: _____/_____/_____ Date of Submission: ____/_____/_____

Prepared by: _____ SC ID #: _____
Name of Service Coordinator

Telephone #: (_____) _____ Fax: (_____) _____

DISPOSITION (Check one)

- ☐ K – Refused prior to IFSP – contact in 2 months
- ☐ L – Age out, not eligible for 3-5, no referrals
- ☐ C – Can't locate family
- ☐ E – Evaluation/Screening found not eligible
- ☐ N – Age out, eligibility for 3-5, unknown
- ☐ I – Child died
- ☐ H – Moved out of state, specify below
- ☐ B – Parent refused EI services at or after IFSP
- ☐ D – Transferred to the 3-5 system
- ☐ M – Age out. not eligible for 3-5, referred to other program
- ☐ A – Delay condition resolved
- ☐ Z – Duplicate
- ☐ G – Moved out of New York City, specify:

COMMENTS:

Parent Signature: _____ Date: _____/_____/_____

☐ Parent was unavailable for signature. Explain above.

Parent was informed of monitoring services:

☐ J – Transfer to Developmental Monitoring Unit. Risk Factor: _____

☐ Parent objected to referral for monitoring

Primary Health Care Provider: _____

Address: _____

Telephone #: (_____) _____

Reviewed by EIOD: _____ Date: _____/_____/_____
Signature

***Note:** The service coordinator must send a copy of this form to the transportation and respite provider when applicable.

EIP Data Entry: _____ Date: _____/_____/_____