Early Intervention Program Referral Form

FOR OFFICE USE ONLY

Date of Referral

☐ *Re-open*

1. REQUIRED INFORMATION

CHILD'S NAME *(Last, First, Middle)*

DATE OF BIRTH *(MM/DD/YY)* __ __/__ __/__ __

SEX ☐ Male ☐ Female

CHILD'S ADDRESS: *(Street, Apt. No)*

CITY

Zip Code __ __ __ __ __

RACE (Required – may select more than one if applicable)
☐White ☐Asian ☐Black ☐Native American or Alaskan ☐Hawaiian or Pacific Islander

ETHNICITY (Required)
☐Hispanic ☐ Not Hispanic

MOTHER'S NAME *(Last, First, Middle)*

Caregiver or Alternate Contact Name *(Last, First)*

_____

Telephone (__ __ __) __ __ __- __ __ __ __

Relation to Child ☐ Father ☐ Grandparent ☐Foster Parent ☐ Other, *Specify:*

TELEPHONE

☐Home (__ __ __) __ __ __- __ __ __ __

☐Cell (__ __ __) __ __ __- __ __ __ __

☐Work (__ __ __) __ __ __- __ __ __ __

REASON FOR REFERRAL *(Check only one)*

☑ **EARLY INTERVENTION: Child with a suspected or known developmental delay or disability.**
Fax to the EIP Regional Office in the child's borough of residence:

Bronx	(718) 410-4504
Brooklyn	(718) 722-2998
Manhattan	(212) 487-7071
Queens	(718) 271-6114
Staten Island	(718) 420-5360

☐ **DEVELOPMENTAL MONITORING: Child is developing typically but may be "at risk" for atypical development, *or* child missed or failed newborn hearing screening.**
Fax to the Child Find Office:
Citywide (212) 227-3642

Person Presenting Referral to Early Intervention

Name: EVELYN GONZALEZ

Agency or Facility, if any: LOS NIÑOS SERVICES, INC.

Address *(Street, Apt. No)*: 535 8th AVENUE 2nd FLOOR

City, State, Zip: NY, NY 10018

Telephone (212) 787-9700 Fax (212) 787-4418

Referral Source Type: ☑ Community Program or EI Agency ☐Parent/Family ☐ Foster Care/Other ACS ☐ PCP ☐Hospital ☐ Other *(Specify):*

Comments CONCERN:

2. WITH INFORMED PARENTAL CONSENT

MOTHER'S DATE OF BIRTH *(MM/DD/YY)* __ __/__ __/__ __

PRIMARY HOME LANGUAGE:

CHILD KNOWN TO ACS ☐Yes ☐ No

CHILD'S DOCTOR

DOCTOR'S TELEPHONE (__ __ __) __ __ __- __ __ __ __

BIRTH HOSPITAL

LOCATION

BIRTH WEIGHT *Pounds:* __ __ *Ounces:* __ __ ***OR*** *Grams:* __ __ __ __

Gestational Age: __ __ *weeks*

DIAGNOSIS *if known:*

3. REQUIRES PARENTAL SIGNATURE

HEALTH INSURANCE COVERAGE INFORMATION

I am insured by _____ under policy number _____. I consent to the inclusion of this insurance information in this referral to the New York Department of Health and Mental Hygiene for Early Intervention services for my child. I understand that no services will be billed to my insurance plan until services are authorized for my child.

Only this section requires written parental consent.

_____ Parent Signature

_____ Date

Request for ISC

Requested ISC SC ID No.

Agency ID No.
LOS NIÑOS SERVICES, INC. 56900

Tel. Fax
(212) 787-9700 (212) 787-4418

Reason for ISC Request PARENT'S SELECTION

FOR OFFICE USE ONLY **ISC Request** ☐ **Approved** ☐ **Not Approved**

Assigned SC SC ID No.

Agency ID No.

Tel. Fax
(__ __ __) __ __ __- __ __ __ __ (__ __ __) __ __ __- __ __ __ __

Data Entry Date
__ __/__ __/__ __

Questions? Dial 311 and ask for Early Intervention **EIP 04/09**