



Attention: Dr. _____
cc: Jeff Hoffman
EHDI Program Manager, DHHS

Date: _____

Child's Name: _____

Child's Date of Birth: _____

Services
Coordinator/District
Case Manager: _____

Referral by: _____

Phone Number: _____

Verification: _____

Current Goals and Family Priorities:

1. _____
2. _____
3. _____
4. _____

Child's IFSP/IEP Team includes:

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> P.T. | <input type="checkbox"/> Services Coordinator | <input type="checkbox"/> Deaf Educator |
| <input type="checkbox"/> O.T. | <input type="checkbox"/> Early Childhood Special Educator | <input type="checkbox"/> Paraeducator |
| <input type="checkbox"/> S.L.P | <input type="checkbox"/> School Psychologist | <input type="checkbox"/> Autism Spectrum
Consultant/s |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Teacher for the Visually Impaired | |

Other Resources and Supports being utilized by the family are:

- | | |
|--|--|
| <input type="checkbox"/> Respite Reimbursement | <input type="checkbox"/> Early Head Start-Home Visits |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Early Head Start-Center Based |
| <input type="checkbox"/> Parents Supporting
Parents | <input type="checkbox"/> Medical Therapy |
| <input type="checkbox"/> Preschool | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Preschool
Transportation | <input type="checkbox"/> SSI |
| <input type="checkbox"/> MHCP | <input type="checkbox"/> Aged & Disabled Waiver (includes funding for disabled
childcare, respite care, nursing & nutrition services, home
modification, others) |
| <input type="checkbox"/> Other: | <input type="checkbox"/> DCP (reimbursement for respite and mileage, meals and
lodging for medical appointments) |

If you would like a copy of the IFSP/IEP or the evaluation report please contact the services coordinator/District case manager listed above