DCFS/Early Intervention Information Form

Children under age 3 (birth – 35 months)

Agency Referred To: _____ Referral Date: _____
Agency Referred To Phone #: _____ Fax #: _____

Child's Name	M/F	Date of Birth	Soc. Sec. # (Optional)	Medicaid/CHIP # (Optional)
Child's Ethnicity: ○ White ○ Hispanic ○ Other				
Child's Language: ○ English ○ Spanish ○ Other				

Parent or Guardian to Contact: _____

Family Phone #: _____ Alternate #: _____

Family Address: _____ City, State, Zip: _____

Referring Worker: _____ Phone #: _____ Email: _____

- Concerns of the Parent/Caretaker:

- Concerns of the Worker:

Instead of contacting Baby Watch Early Intervention on my own, I have requested that my DCFS worker make the contact for me. If my child is eligible for Early Intervention Services, I understand that these services are voluntary. I understand a representative from Baby Watch Early Intervention will contact me.

Consent for Coordinated Services and Release of Information

I understand that my child's Developmental Screening, as completed by the DCFS worker, and myself is protected under State and Federal regulations as well as professional codes of ethics governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in State and Federal regulations. I authorize the release of information to Early Intervention with the restriction that said information cannot be passed on to any other person outside their agency without my consent.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date