Early Intervention Program Referral Form

- Anyone can make a referral by filling out this form or by calling 311 and asking for "Early Intervention."
- Administration for Children's Services (ACS) employees or agencies contracted with ACS must call the Citywide ACS Referral Hotline: 877-885-KIDZ (5439) to make referrals.
- For updates on the child's progress through the Early Intervention process, contact the child's service coordinator. Early Intervention is confidential. Parent/guardian written consent is required before information can be released.

1. REQUIRED INFORMATION

Child Info

Child's Name: *(First, Middle, Last)* | **Referral Date:***(MM/DD/YY)*

Birth Date: *(MM/DD/YY)* | **Ethnicity:** ☐ Hispanic ☐ Not Hispanic | **Sex at birth:** ☐ Male ☐ Female

Race: *(select all applicable)* ☐ White ☐ Black ☐ Asian ☐ Native American/Alaskan ☐ Hawaiian/Pacific Islander

County of Residence: *(borough)* Select | **Child Known to ACS?** *(ward of social services)* Y ☐ N ☐

Primary Language: | **If Multilingual, Secondary Language:**

Child Address

Primary Address Type: ☐ Biological Parent ☐Foster Care Parent ☐ Residential Facility ☐ Hospital ☐ Other:_____

Primary Street Address: _____

City: **State**: **Zip Code**:

Select Only One

REFERRAL REASON

☐ **EARLY INTERVENTION (EI):** Child with a suspected or known developmental delay or disability living in **any** NYC Borough

Fax this form to the Citywide Early Intervention Referral Unit: **347-396-8801**

Suspected of Delay Primary Area of Concern (EI):
☐ Adaptive ☐Cognitive ☐Communication ☐Physical ☐ Social/Emotional ☐ Diagnosis:

☐ **DEVELOPMENTAL MONITORING (DM):** Child is developing typically but may be "at risk" for atypical development, ***or*** child missed or failed newborn hearing screening.

Fax this form to DM/Child Find Citywide Referral Line: **347-396-8869**

At Risk of Delay Referral Reason (DM):
☐ Birth weight: 1,000-1,500 grams ☐ Failed Hearing Screen ☐ Other (See Appendix A):

Referral Source

Referral Source Type: ☐EI Provider ☐Hospital ☐Healthcare provider ☐Parent/Family ☐Social Service Agency ☐ Other, specify:

Referral Source Name: *(First, Last)*

Agency/Facility Name: | **Phone**:

Family Information

Primary Caregiver: (First, Last): | **Date of Birth:**

Caregiver Type: ☐ Birth Mother ☐ Birth Father ☐ Foster Parent ☐ Legal Guardian ☐ Other: | **Dominant Language:**
Address same as child? ☐ Y ☐ N (if no, enter below)

Telephone: Cell: Home: Work:

Alternate Caregiver: (First, Last): | **Date of Birth:**

Caregiver Type: ☐ Birth Mother ☐ Birth Father ☐ Foster Parent ☐ Legal Guardian ☐ Other: | **Dominant Language:**
Address same as child? ☐ Y ☐ N (if no, see below)

Telephone: Cell: Home: Work:

Street Address (for ☐Primary ☐Alternate Caregiver, if **different** than child):

City: | **State**: | **Zip Code**:

2. REQUIRES INFROMED PARENT CONSENT

Child in a Health Home? ☐ Y ☐ N **Agency Name**: **Phone**:

Child's Doctor: | **Doctor's phone:**

Birth Weight: *Pounds:* *Ounces:* **OR** *Grams:* **Gestational Age***:* *weeks*

Parent may request an Initial Service Coordination Agency/Coordinator:

The parent /caregiver requested BIG APPLE CHILDREN SERVICES/

3. REQUIRES PARENTAL WRITTEN CONSENT

Parental Consent to Receive Early Intervention/ Developmental Monitoring Welcome Letter by Email

I give permission for the NYC Early Intervention Program to send me my child's Welcome Letter from email address: ReferEI@health.nyc.gov to my email address at: . The letter includes the child's name, date of birth, and the name & phone number of the assigned Initial Service Coordinator.

Parent/Guardian Signature: Date:

Need Help? Call 311 and ask for "Early Intervention Referral." **EIP 10/2024**

Instructions for Completing the Early Intervention Program Referral Form

(Please do not fax with the referral form)

NOTE TO REFFERAL SOURCE:

- **ACS Referral Hotline: Child who has a suspected or known delay OR Child who is typically developing but may be "at risk" for atypical development AND is involved in ACS Foster Care, Protective Services or Preventive Services.** Early Intervention Specialists at the ACS Hotline will discuss appropriate next steps in the Early Intervention process. **All referrals coming from ACS must be called in using this designated hotline number.** Fax transmission is discouraged for ACS referrals.
- For updates on the child progress through the Early Intervention process after the referral is made, contact the child's service coordinator. The parent will receive a Welcome letter approximately one (1) week after the referral is made with the name and contact information of the child's assigned service coordinator. Early Intervention is confidential. Parent/guardian consent to share information is required before any information can be released.

Write legibly or type all referral information. The referral form is divided into three (3) sections.

Section 1 - Contains information fields that **must** be included when making a referral to the NYC Early Intervention Program (EIP). Submitting the information in Section 1 does not require parental consent. **This section should be filled out completely for the referral to be accepted.**

Note: Family has the right to refuse to have their child referred to EIP. However, written consent is not needed to submit a referral to the EIP.

Section 2 - Contains information that should be transmitted only with **informed parental consent**. Consent can be verbal or taken from another consent form used by the referring agency.

Section 3 - Contains information that requires a parent to indicate that they are giving **written signature** on this Referral Form.

The information contained in Sections 2 and 3 is important for appropriate routing of the referral and assignment of Initial Service Coordinator (ISC). Therefore, it is recommended that all sections be completed if possible, with parental consent obtained as indicated.

Information on this form must be typed or printed legibly.

Section 1: Required Information

Child Information

1. Write the child's full name: first name, then last name. Write the referral date (the date you are completing this form) using two (2) digits each for month, day and year (e.g., 03/25/22). Enter the child's date of birth in the same format.
2. Check the appropriate boxes for ethnicity, sex assigned at birth, and race. *More than one race can be selected.*
3. Enter the borough where the child resides.
4. Check the box to indicate whether the child is known to ACS. This includes Protective services, Preventive services, and Foster Care.
5. Enter the child's primary language. If the child speaks more than one language, enter the child's second language.

Child Address

6. Write the full address where the child lives, including the city (borough) and zip code. Indicate whether the child lives at that address with a biological parent, foster parent, or other adult, or if the address is a hospital or residential facility.

Referral Reason

7. Check either **Early Intervention** OR **Developmental Monitoring**. If the child is being referred because of a concern in a particular area, check off that concern under **Suspected of Delay Primary Area of Concern (EI)**. When making a DM referral, indicate **At Risk of Delay Referral Reason (DM)**. See Appendix A for examples.
   All ACS referrals must be called in using the designated hotline number. Fax transmission is discouraged for ACS referrals.

Referral Source

8. Person Making the Referral: Check the box for the type of person or institution making the referral. Social service agency might include Department of Homeless Services/shelter personnel, SNAP, WIC, etc. Enter the name of the person, first name, then last name. If that person works for an agency or facility, enter the agency/facility name. Provide a phone number.

Family Information

9. Write the name of the child's primary caregiver, first name, then last name. Provide that person's date of birth, if known, using two (2) digits each for month, day and year (e.g., 03/25/22). Check the box for birth mother, birth father, foster parent, legal guardian or check Other and write in the person's relationship to the child. Examples of other caregivers include family members such as grandmother and aunt. Indicate the caregiver's primary language, and whether they live at the same address as the child. Provide all contact phone numbers available for the caregiver.
10. If an alternate caregiver is known, enter the same information for that person as for the primary caregiver.
11. If either caregiver lives at a different address than the child, write the address, city (borough), state and zip where they live, and indicate whether this address is for the primary caregiver or the alternate caregiver.

Section 2: Requires Informed Parent/Guardian Consent

1. Indicate if the child is in a Health Home. If they are, give the name of the Health Home agency and the phone number.
2. Write the name of the child's doctor and their telephone number.
3. Write the child's birth weight in pounds and ounces, or grams. Include the gestational age in weeks, if known.

4. If the family is requesting a particular initial service coordinator (ISC), write the name of the ISC, and the name of the SC agency, and the telephone numbers for the agency. Include the reason for the request. According to NYS law, a specific ISC or ISC agency can be requested when there is "an established relationship with the child or family." However, final ISC assignment is at the discretion of the EI Regional Office.

Section 3: Requires Written Parent/Guardian Consent

1. For referrals to EI: The parent must sign to consent for EI to send their child's Welcome Letter by email, from the address ReferEI@health.nyc.gov. The letter contains the child's name, date of birth, and the name and phone number of the assigned Initial Service Coordinator. The parent must provide the email address where the welcome packet should be sent.

Appendix A- Reason for Referral Clarification

Section 1 contains the REFERRAL **REASON** section. The individual referring the child must indicate whether the child is being referred to **EIP via the Citywide Early Intervention Referral Unit, or Developmental Monitoring (DM) (Child Find)**. The following indicators should assist with deciding which REFERRAL **REASON** box to check and where to send the referral.

EARLY INTERVENTION: Child with a suspected or known developmental delay or disability.

This referral is sent to the Citywide Early Intervention Referral Unit for a Multidisciplinary Evaluation (MDE). Check this box for a child with a developmental delay(s) and/or a diagnosed physical or mental condition with a high probability of developmental delay. The child should meet one or more of the following criteria:

- The child has a condition with a known likelihood of leading to a developmental delay such as Down Syndrome, a birth weight of less than 1,000 grams (2.2 pounds), failure of two (2) hearing screenings or a confirmed hearing or vision loss;
- The results of a developmental screening or diagnostic procedure, direct experience, observation, and perception of the child's developmental progress indicate that he or she is not developing similarly to same age peers; or
- Parent or caregiver requests an evaluation or has provided information that indicates the possibility of a developmental delay or disability.

DEVELOPMENTAL MONITORING (Child Find): Child is developing typically but may be "at risk" for atypical development, or child missed or failed a newborn hearing screening or re-screening (*not re-screened within seventy-five (75) days from birth).*

This referral is sent to DM/Child Find Citywide Referral Line. Check this box for a child who missed or failed their newborn hearing screening and did not return for follow-up within seventy-five (75) days from birth. Also, check this box for a child who meets one or more of the risk criteria listed below:

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
• Birth weight less than 1,501 grams • Gestational age less than 33 weeks • NICU stay of ten (10) days or more • CNS insult/abnormality • Asphyxia (5 min Apgar 3 or less) • Growth deficiency/nutritional problems (e.g., SGA) • Presence of Inborn Metabolic Disorder • Maternal prenatal alcohol abuse • Congenital malformations • Hyper- or hypotonicity • Hyperbilirubinemia (above 20 mg/dl) • Hypoglycemia (serum glucose less than 20 mg • Maternal prenatal abuse of illicit substances • Prenatal exposure to therapeutic drugs with known risk • Perinatally/congenitally transmitted Infection (e.g., HIV, hepatitis B, syphilis) • Maternal PKU	• Parental developmental disability or diagnosed serious persistent mental illness • Suspected/family history of hearing impairment • Suspected/family history of vision impairment • Genetic syndrome that may confer increased risk for developmental delay • Other risk criteria identified by referral source (describe) • Parental concern re: development • Questionable score on developmental/sensory screen • Illness/trauma with CNS implications requiring ICU more than ten (10) days • Chronic serous otitis media (continuous for at least three (3) months) • Growth deficiency/nutritional problems, FTT, iron deficiency • Venous lead level at or above 5 mcg/dl • HIV infection	• No prenatal care • Parental drug or alcohol abuse • History of child abuse or neglect* • No well-child care by six (6) months • Concern with parenting due to poor bonding, impairment in psychological/interpersonal functioning • Significant immunization delay * Referrals of typically developing children in ACS Foster Care who have not been screened should be sent to DM