DSS Referral Form for Early Intervention Services (CDSA)

(Referral must be completed and sent to Early Intervention Services **within 72 hours of Substantiation or In Need of Services Finding**)

(Please attach copy of DSS Family Strengths and Needs Assessment)

Date of DSS Referral: Date of DSS Finding of "Substantiation" or "In Need of **Services":**

Basis of "Substantiation" or "In Need of Services":

Child's Name:
Date of Birth:_____ Male____ Female :____
Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Language, if other than English
Address

Telephone Number:
Referring County Department of Social Services:

DSS Contact Person Telephone:
Parent/Caretaker Name:
(If parent is not legal guardian, list who has legal custody and how they can be contacted)

Legal guardian contact information

Does parent/caretaker have any known or suspected physical or mental health problems?

Is parent/caretaker involved with any other agencies or medical providers?

Any prior assessments for medical and/or developmental needs? By whom?

Does child have any diagnosed or suspected developmental delays or other special needs?

Child's primary medical provider. (Please provide telephone number and/or address)

Is child seen by any other social service agency or medical provider?

Child has: Medicaid/HealthChoice? (Y/N)____ Other Insurance? (Y/N)___Other?

(see reverse of form)

Has family been informed about CDSA referral? (Must be done prior to referral)

Any other information that would help Child Developmental Service Agency (CDSA) understand this family

Directions to Home: