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Westchester Institute for Human Development
Cedarwood Hall, Valhalla, NY 10595
914.493.8202 . www.wihd.org

Date:

Dear Parent:

Welcome to the Westchester County Department of Health's Early Intervention Program (EIP).

In response to the referral of your child for Early Intervention services, I have been assigned as your Initial Service Coordinator (ISC), to work with your family during the first phase of your entry into the program, and will assist you in selecting the most appropriate agency to evaluate your child, answer any questions that you have, address your concerns and offer additional information.

I will be scheduling an initial visit within the next few days in order to go over the referral packet and any forms that must be filled out by you and your child's physician. At that time, I will be collecting the following forms and information from you.

*Proof of Residency (Con Ed, phone bill, etc.)
*Copy of Health Insurance Card (front and back)
*Notice of Privacy Practices
*Authorization to Release Health Insurance Information
*Consent to Bill Non-Regulated Insurance
*Parent Consent to Release and Receive Information
*Parent Selection of Evaluator
*****Medical form to be filled out by your pediatrician's office*****
PLEASE return completed medical form to evaluation agency as soon as possible

*WIHD Notice and Consent for Destruction of EI Records
*WIHD Parent Consent to Use E-Mail to Exchange Personally Identifiable Information

I look forward to working with your family.

Yours truly,

Initial Service Coordinator, The Family Connection

Tel#: ______________________________

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Westchester gov.com

Sherlita Amler, M.D.
Commissioner of Health

Westchester County Department of Health

Services for Children with Special Needs

EARLY INTERVENTION PROGRAM INTAKE

CHILD'S NAME:______________________________ DOB:________________

AGENCY:______________________________ INTAKE DATE:______________

INTIAL SERVICE COORDINATOR:__________________ IFSP DATE:______________

EIOD:______________________________ Projected IFSP DATE:__________

THE INTAKE SHOULD ADDRESS THE FAMILY'S CONCERNS, PRIORITIES, and RESOURCES:

Concerns: Family concerns is defined as those areas that the parent identifies as needs, issues or problems that the family wishes to have addressed in the IFSP.

Priorities: Family priorities refers to those areas that the parent selects as essential targets for early intervention services to be delivered to their child and family unit.

Resources: Family resources refers to the strengths, abilities and formal and informal supports that can be accessed to address family concerns, needs or desired outcomes.

1. Has your child been previously referred to the Early Intervention Program?
   Previous Evaluations, EI, Private? ____

2. What was happening with your child that bought you to Early Intervention? Family concern.

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Sherlita Amler, M.D.
Commissioner of Health

CHILD'S NAME: ______________________________ DOB:__________

3. Tell me about your child? What does your child enjoy?
   PROMPT: What are the typical activities and routines of the day for you and your child?

4. Tell me about your family? (siblings, extended family, caregivers)
   PROMPT: Who is involved with your child and who can you call on for support for you and your family? ______________________________

5. Are you looking for information or resources outside of the Early Intervention Program?
   PROMPT: Does your family need help finding community services? ______________

6. Do you have insurance? What type of coverage do you have?
   PROMPT: Do you have Medicaid, SSI, Child Health Plus, Commercial Insurance?

7. Does your child have a Pediatrician, Neighborhood Health Center?
   Physician's name and telephone number:______________________________

   Neighborhood Health Center Physician's name and telephone number: ______________

8. In order for me to assist you in selecting an evaluator, does your child have an existing medical condition or special needs? ______________________________

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Sherlita Amler, M.D.
Commissioner of Health

CHILD'S NAME: ______________________________ DOB: ______________

9. Discuss EI process, refer to the Parent Guide to Early Intervention.
   - timeline, 45 day, eligibility
   - selection of evaluator, multidisciplinary evaluation
   - IFSP meeting, role of EIOD
   - selection of the Ongoing Service Coordinator
   - due process rights

____
____
____
____

10. Discussion on family responsibilities and participation in the Early Intervention Program.
    PROMPT: If child is eligible, discuss with parent what their role is in the intervention process. i.e. Family Centered Intervention. ______________________________

____
____
____
____

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WESTCHESTER COUNTY DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM

PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

Child's Name: ____
Last First

Child's DOB: _____/_____/______

I have been informed by the Early Intervention Initial Service Coordinator (ISC) of the various programs and services the Early Intervention Program (EIP) can provide to my child. I have also been informed that in order to provide such services it will be necessary for the Program to coordinate and exchange information with appropriate service providers.

☐ I consent to the planning and coordination of services for my child.

______________________________________ Date_____/_____/______
Signature of Parent/Guardian

______________________________________ Date_____/_____/______
Signature of Initial Service Coordinator

Service Coordinator Must Complete:

Date ISC agency received assignment from WCDOH: _____/_____/______

Date ISC provided parent(s) the EIP Parent's Guide: _____/_____/______

Date ISC reviewed "Your Parent's Rights in the EI Program": _____/_____/______

Date ISC reviewed list of evaluation sites and discussed choice of evaluation site with parent: ____/____/_____

Name of evaluation site selected by parent: ______________________________________

Date referral made to evaluation site: _____/_____/_____

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WESTCHESTER COUNTY DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM

PARENT SELECTION OF EVALUATION AGENCY

Child's Name: ____
Last First MI

DOB: _____/_________/__________ Date of Referral: _____/_____/_____

My initial service coordinator has reviewed all options for evaluations and provided me with a list of NYSDOH approved evaluation agencies in Westchester County.

I have been informed that I will be involved in my child's evaluation, I will receive the results of all evaluations, and that a copy of all evaluations will be forwarded to __________________________________, my assigned Early Intervention Official Designee (EIOD). If my child is eligible for the Early Intervention Program, the evaluations will assist in developing my child's Individualized Family Service Plan (IFSP).

I choose ____ as the evaluation agency that will determine my child's eligibility for the Early Intervention Program. In the event that this evaluation agency does not have availability I choose ____________________________, ____________________________.
(Evaluation Agency 2nd choice) (Evaluation Agency 3rd Choice)

____ Date: ____/____/____
Signature of Parent/ Surrogate Parent

Revised 6/11/14

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Westchester County Department of Health
Children with Special Needs

Patient Bill of Rights/Notice of Privacy Practices

I have been provided the opportunity to review the Westchester County Department of Health's Notice of Privacy Practices and Patient Bill of Rights prior to signing this document. The Notice of Privacy Practices for the Westchester County Department of Health is also provided on the Westchester County Department of Health's website at http://health.westchestergov.com/.

Record Retention Policy

In accordance with the State Archives and Records Administration, Early Intervention records are maintained by Westchester County until the child turns 21 years old, at which time the record will be destroyed. The county may however maintain a permanent record of the child and family's name and address, and the types and dates of services received without time limitation.

I acknowledge that Westchester County's Notice of Privacy Practices and Record Retention Policy have been reviewed with me.

Signature of Parent/Guardian	Relationship to Child	Date

Westchester Institute for Human Development
Notice and Consent for Destruction of Early Intervention Records

Early Intervention (EI) records are considered educational and are governed by the following regulations related to the retention and destruction of records containing personally identifiable information.

- Federal family Educational Rights and Privacy Act (FERPA)
- Title II-A of Article 25 of Public Health Law
- Intervention Program regulations in 10 NYCRR 69-4.17 (c)
- Title 34 of the code of Federal Regulations (CFR)

Personally Identifiable Information (PII), as used in information security, refers to information that can be used to uniquely identify, contact, or locate a single person or can be used with other sources to uniquely identify a single individual.
The Federal Government defines PII as "*Information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name"*
The records created for your child throughout the Early Intervention process will be retained by WIHD until they reach the age of 21 at which time they will be destroyed by us in a manner consistent with all Federal, state and local regulations and laws in effect at that time.
<u>The process used for destruction of these records may include the use of an outside record disposal company that Westchester Institute for Human Development contracts with specifically for this purpose. The company provides us with a certificate of destruction which is kept on file at WIHD in the Office of Corporate Compliance and Regulatory Affairs. Companies who contract to provide this service will be in full compliance with all Federal, state and local regulations in effect at the time the records are destroyed.</u>
<u>You</u> may request that the documents be destroyed earlier by submitting a request in writing to:

Westchester Institute for Human Development
Manager of the Early Intervention Program
Cedarwood Hall
Valhalla, New York 10595

Please be aware that you or your child may need the Early Intervention records for future purposes including determination of Social Security Benefits.

By signing this document, I acknowledge that the Policy of WIHD for retention and destruction of Early Intervention records has been explained to me and I consent to the destruction of these records including the use of an outside record destruction company who will be fully compliant with all federal, state and local regulations regarding destruction of personally identifiable information.

______________________	______________________
Child's Name	Child's Date of Birth
Name of Parent or Guardian	Signature of Parent or Guardian
Relationship to Child	Date

Reviewed 4/2016

Parental Consent to Use E-mail and/or Texting to Exchange Personally Identifiable Information

Parent's Name: ______________________________

E-mail Address: ______________________________ Cell Phone: ____________

Child's Name: ______________________________ D.O.B. ____________

At your request, you have chosen to communicate personally identifiable information concerning your child's early intervention treatment by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parental Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using **e-mail** to communicate personally identifiable information. Nevertheless, I, ______________________________, authorize ______________________________ whose e-mail address is ______________ to communicate with me at my e-mail address, ______________________________, or via texting to my cell phone concerning my child's, ______________________________, participation in the Early Intervention Program (EIP), including but not limited to communication regarding service delivery, his/her progress in the EIP and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for members of my child's treatment team to communicate personally identifiable information concerning my child with each other using **unencrypted e-mail or texting.** Early intervention team members who I give permission to use **unencrypted e-mail or to text** to communicate with each other about my child include:

(1) ______________________ at the e-mail address ______________________ Phone to text______________

(2) ______________________ at the e-mail address ______________________ Phone to text______________

(3) ______________________ at the e-mail address ______________________ Phone to text______________

(4) ______________________ at the e-mail address ______________________ Phone to text______________

(5) ______________________ at the e-mail address ______________________ Phone to text______________

Parent's Signature ______________________________ Date ______________

(Rev. 05/12/2016)

Please fax to:

Westchester County Department of Health
Early Intervention Program Medical Form

Child's Name: ______________________ Date of Birth: __________

Parent's Name: ______________________

Address: ______________________

Immunization History:

	Birth – 2 Months	4 Months	6 Months	12-18 Months	18-24 Months	24-30 Months	30-36 Months
(DtaP) Diphtheria, Tetanus, Pertussis							
(IPV) Polio							
(Hib) Haemophilius Influenzae type b							
(Hep B) Hepatitis B							
(MMR) Measles, Mumps, Rubella							
(PCV) Pneumococcal Conjugate							
Chickenpox) (Varicella)							

Testing: Lead: ________ **Results:** ________ **TB:** ________ **Results:** ________
Date of Last Physical Exam: ______ **(Ht.)** _____**inches**______**% (Wt.)** _____**lbs.**_____**%**
Ophthalmology: ______________**Results:** ______________
Audiology: ______________ **Results:** ______________
Referrals to other physicians: ______________

Please describe below or attach description of child's medical history that has an identified or potential impact upon his developmental growth: Birth defects, prematurity, addiction, respiratory/cardiac compromise, seizure activity, feeding difficulties, other pre-natal or neo-natal difficulties or history of accidents, injuries, hospitalization, etc.

Please describe child's current medications, medical needs or concerns including allergies, if any:

Please describe any emotional, social or behavioral problems of which you are aware:

I hereby recommend that this child receive services from Early Intervention that may include occupational therapy, physical therapy, speech, social work, and/or assistive technology services; if found eligible as per EI NY State Regs. and as per the IFSP.

Physician's Name: ______________________

Address: ______________________

______________________ Phone #: __________

Signature: ______________________ Date: __________

Revised.2/11

Insurance Tool Kit Item 3 Form A

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

NYEIS Child Reference#:

COLLECTION OF INSURANCE INFORMATION

DATE INSURANCE INFORMATION COLLECTED/UPDATED:	*Is the Insurance Plan Regulated by New York State? Yes ☐ No ☐ If no, has the parent consented to use of their insurance benefits? Yes ☐ No ☐	Is the Insurance Plan: Primary ☐ or Secondary ☐
Child's Name:	Child's Date of Birth:	Child's Gender:
Parent/Guardian Name:	Parent/Guardian Date of Birth:	Parent/Guardian Phone No.:
Insurance Company Name:	Insurance Company Phone No:	**Insurance Company Billing and Claiming Address:
	Insurance Plan/Policy Name:	Type of Insurance Plan:
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder Gender:
Policy Holder Address:	Policy Holder Phone Number:	Policy Holder Relationship to Child:
Policy Holder Employer Name:	Employer Address:	Employer Phone No.:
Policy No. for Billing:	Child's Member Identification No:	Group Number (if applicable):
	Policy Effective From Date:	Policy Effective To Date:
Is the Plan Child Health Plus? Yes ☐ No ☐	Is the Plan Medicaid Managed Care? Yes ☐ No ☐	Is the Plan a self-funded plan? Yes ☐ No ☐
***Medicaid CIN Number (2 alpha, 5 numeric, 1 alpha):	CIN Effective From Date:	CIN Effective To Date:
Service Coordinator Name:	Service Coordinator Phone No:	Service Coordinator Fax No.:
Municipality Name:	Service Coordinator Agency:	Service Coordinator Address:

Insurance information must be reviewed at least every six months:

Insurance Information reviewed at 6 month IFSP:	date________	initials __________	no changes ____	new form ____
Insurance Information reviewed at 12 month IFSP:	date________	initials __________	no changes ____	new form ____
Insurance Information reviewed at 18 month IFSP:	date________	initials __________	no changes ____	new form ____
Insurance Information reviewed at 24 month IFSP:	date________	initials __________	no changes ____	new form ____
Insurance Information reviewed (other):	date________	initials __________	no changes ____	new form ____

NYEIS Child Reference #:

Insurance Tool Kit Item 4
Form B

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CHILD INSURANCE INFORMATION

Child's Name/Date of Birth: ______________________________ **Child's Gender:** male ☐ female ☐

Primary Insurance Information:

Insurance Company/Plan Name: ______________________________

Insurance Company Billing address: ______________________________

Policy/Identification (ID) Number: ______________________________

Child's Member ID (if different): ______________________________

Group #: ______________________________

Policy Holder Name: ______________________________ Policy Holder Gender: male ☐ female ☐

Policy Holder Date of Birth: ______________________________

Policy Holder Address: ______________________________

Policy Holder Phone Number: ______________________________

Policy Holder relationship to child: ______________________________

Other Insurance (if applicable):

Insurance Company/Plan Name: ______________________________

Insurance Company Billing address: ______________________________

Policy/ID Number: ______________________________

Child's Member ID (if different): ______________________________

Group #: ______________________________

Policy Holder Name: ______________________________ Policy Holder Gender: male ☐ female ☐

Policy Holder Date of Birth: ______________________________

Policy Holder Address: ______________________________

Policy Holder Phone Number: ______________________________

Policy Holder relationship to child: ______________________________

Medicaid Client Identification Number (CIN) (if applicable): ___ ___ ___ ___ ___ ___ ___ ___
(2 letters, 5 numbers, 1 letter)

______________________________ ______________
Parent/Legal Guardian Signature Date

Parent signature confirms that the insurance information on file is correct.

Insurance Information reviewed at 6 month IFSP:	date________	no changes ____	parent signature ______________
Insurance Information reviewed at 12 month IFSP:	date________	no changes ____	parent signature ______________
Insurance Information reviewed at 18 month IFSP:	date________	no changes ____	parent signature ______________
Insurance Information reviewed at 24 month IFSP:	date________	no changes ____	parent signature ______________
Insurance Information reviewed (other):	date________	no changes ____	parent signature ______________

PARENT ATTESTATION OF NO INSURANCE (if applicable)

Child's Name: ______________________________ **Child's Date of Birth:** ____________

I ______________________________ (please print name) the parent and/or legal guardian of the child whose name is above, attest that as of today's date such child does not have health insurance coverage. I understand that the assigned Early Intervention Program service coordinator must assist me with the identification of and application for health insurance for which such child may be eligible. I also understand that such child is not required to have health insurance in order for Early Intervention Program services to be provided.

______________________________ ______________
Parent/Legal Guardian Signature Date

Revised May 2017

NYEIS Child Reference #:

Insurance Tool Kit Item 5 **Form C**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

AUTHORIZATION TO RELEASE HEALTH INSURANCE INFORMATION

Pursuant to Section 2559(3)(d) of NYS Public Health Law and
Section 3235-a(c) of the Insurance Law

Insured's (Child's) Name:	Date of Birth:
Parent/Legal Guardian's Name:	Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name and Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Service Coordinator Name:	Service Coordinator Agency:
Service Coordinator Address:	Service Coordinator Phone No.:
Municipality:	Date Sent to Insurer:

I request and authorize the release of health insurance coverage information for the insured named above to my child's and family's early intervention service coordinator, provider(s), the municipality which administers the local Early Intervention Program, and the NYS Department of Health and/or its early intervention fiscal agent.

I authorize the exchange of information between these parties and the insurer named above for the purposes of facilitating claiming and assisting in the adjudication of claims for services rendered under the Early Intervention Program:

I further consent and authorize providers who submit claims to the above referenced insurer to provide such information as may be required by the insurer to facilitate claiming and payment for services rendered under the Early Intervention Program.

This request applies only to health insurance coverage under the insured's policy, plan or benefit package for the purposes of facilitating payment from the insurer for services rendered under the Early Intervention Program.

Parent/Guardian's Signature: ______________________________

Date Signed: ______________________________

NYEIS Child Reference #:

Insurance Tool Kit Item 10 **Form F**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CONSENT TO BILL NON-REGULATED INSURANCE

TODAY'S DATE:	*Is the Insurance Plan Regulated by New York State: Yes ☐ No ☐
Child's Name:	Child's Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name:	Policy Holder's Relationship to Child:
Policy Holder's Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Name of Service Coordinator:	Service Coordinator's Phone Number:
Consent Effective From Date:	Consent Effective To Date:

Please Read

I understand that I can decide if I wish to give my permission for my health insurance plan, which is <u>not</u> regulated by New York State Insurance Law, to be billed to help pay for the Early Intervention Program services my child and family receive.

I understand that my consent is voluntary, that I can revoke my consent at any time, and that the revocation of consent will not be retroactive.

I understand that if I give this permission, my insurance benefits may not be protected by State Insurance or Public Health Law and that my insurer <u>may not</u> be prohibited from:

- Applying the early intervention services to the policy's lifetime or annual monetary or visit limits.
- Discontinuing or not renewing my insurance coverage because my child receives early intervention services.
- Increasing my insurance premiums because my child is receiving early intervention services.

Consent to Bill Non-Regulated Insurance

☐ **I give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

☐ **I do NOT give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

Parent Name Parent Signature Date

NYEIS Child Reference#:

Insurance Tool Kit Item 6 **Form D**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

REQUEST FOR COVERAGE INFORMATION
Pursuant to Section 3235-a(c) of New York State Insurance Law

Child's Name (First/MI/Last):	Child's Date of Birth:
Municipality:	Date Sent to Insurer:
Name of Parent/Legal Guardian:	Phone No.:
Insurance Company/Plan Name:	Insurance Company Address:
Policy Holder Name and Address:	Policy Holder Relationship to Child:
Policy Holder Date of Birth:	Policy No. for Billing:
Policy Holder Employer Name:	Policy Holder Employer Address:
Child's Member Identification No.:	Group No. (if applicable):
Early Intervention Service Coordinator:	Service Coordination Agency:
Service Coordinator Phone No.:	Service Coordinator Fax No.:
Service Coordinator Address:	

Dear Insurer:

This form requests information about the above named child's insurance coverage. The parent/guardian of the above named child has authorized release of this information (authorization form enclosed). As per requirements in Section 3235-a(c) of the New York State Insurance Law, we request that you complete and return this form to the Early Intervention Program at the address provided above. Section 3235-a(c) of the State Insurance Law requires this information to be returned within 15 days of request. Provision of this information will assist both the authorized providers and the insurer in claims processing.

Please provide the following requested information regarding the above named child's benefits as the insured.

Is the child's health coverage:

a) A health insurance policy, plan or benefit package regulated under New York State Law — Yes☐ No☐

b) Child Health Plus — Yes☐ No☐

c) Other government plan (e.g., Medicaid Managed Care) — Yes☐ No☐

d) A self-insured plan governed by ERISA or other plan not subject to regulation under New York State Insurance Law? — Yes☐ No☐

Please indicate the effective dates of coverage for this policy: ______________________________

Revised May 2017

NYEIS Child Reference#:

Child's Name (First/MI/Last):	Child's Date of Birth:

Visit Limit Information

If the child's insurance policy, plan or benefit package **IS** a policy regulated by New York State Insurance Law and **IS NOT** Medicaid, Champus, or a self-insured plan or other plan not subject to New York State Insurance Law, please indicate the number of annual visits available for the covered services identified below (if no coverage is available, please indicate by placing a 'N' in the second column and a '0' in the third column).

Service	Covered (Y/N)	Number of Annual Visits
Applied Behavior Analysis		
Assistive Technology/Durable Medical Equipment		
Audiology Services		
Nursing Services		
Diagnostic and Evaluation Services		
Nutrition Services		
Occupational Therapy		
Physical Therapy		
Psychological Services		
Social Work Services		
Special Instruction		
Speech Language Therapy		
Vision Services		

Is prior authorization for covered services required? Yes☐ No☐

Are there specific referral procedures that must be followed? Yes☐ No☐

If yes, please describe the procedures that must be followed:

____

____

Please provide the name, telephone number, and email address of an appropriate contact person for questions about the information on this form:

____________________	____________	____________
Name	Phone	E-mail

Please return completed form to the Early Intervention Service Coordinator at the address on the first page of this form. Thank you for your assistance.

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Westchester Institute for Human Development
Cedarwood Hall, Valhalla, NY 10595
914.493.8202 . www.wihd.org

CONFIRMATION OF INITIAL IFSP MEETING

DATE: ____________________

RE: ____________________________

Dear ____________________________:

This is to confirm that your Individualized Family Service Plan (IFSP) meeting is scheduled as follows:

Date: _______________________

Time: _______________________

☐ The Family Connection
WIHD/Cedarwood Hall
Room 338
Valhalla, NY 10595

☐ Westchester County Dept of Health
145 Huguenot Street, 7th Floor
New Rochelle, NY 10801

☐ Other: ____________________
____
____

At the meeting, you will discuss your concerns and priorities, as well as your child's strengths. The evaluation will also be reviewed. A plan will be developed for your family. Please, also note, that you are required to furnished your child's social security number, as well as the insurance policy holder's social security number, at the time of the meeting, if you have not previously done so.

You may wish to invite anyone else to participate in this meeting.

I look forward to seeing you there.

Sincerely,

____
Initial Service Coordinator, The Family Connection

Phone#: _________________________________

cc: ( ) EIOD ____________________________
( ) Evaluator __________________________
( ) Other ____________________________

Family Connection

WIHD/338 Cedarwood Hall
Valhalla, NY 10595
(914)493-1343 (phone)
(914)493-8066 (fax)
(914)493-2639 (alternate fax)

To:
Fax number:

From:
Fax number:

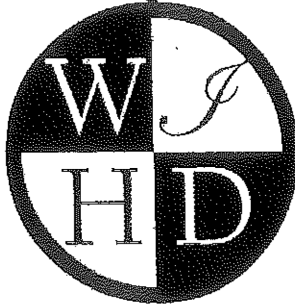
Date:

Regarding:

Phone number for follow-up:

Comments:

The information contained in this facsimile message is confidential information intended for the use of the addressee listed above. If you are neither the intended recipient, not the employee nor agent responsible for delivering this message to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance of the contents of this telecopy information, is strictly prohibited. If you have received this telecopy information in error, immediately notify us by telephone to arrange for return of the original documents to us. Thank you.



Westchester Institute
for Human Development
Family Connection – Early Intervention Services
Cedarwood Hall, Room 338
Valhalla, New York 10595

914-493-1343 (p)
914-493-8066 (f)
914-493-2639 (alternate f)

facsimile transmittal

To:	From:
To Fax:	Phone # for follow-up:
Pages:	Date:

CONFIDENTIALITY NOTICE: The information in this communication and any attachments is intended only for the use of the addressee and may contain information that is privileged, business sensitive, strictly private, confidential, or exempt from disclosure. If the reader of this notice is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender and delete the communication without retaining any copies.