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
*Parent Consent to Release and Receive Information
*Parent Selection of Evaluator
*WIHD Notice and Consent for Destruction of EI Records
*WIHD Parent Consent to Use E-Mail to Exchange Personally Identifiable Information
*Medical form to be filled out by your pediatrician’s office

**PLEASE return the completed medical form to the evaluation agency as soon as possible**

If you would like to review these forms in advance you can visit our web page at: www.wihd.org/individuals-families-caregivers/early-intervention-family-connection/

The forms are located on the right sidebar under Early Intervention Forms and Documents.

I look forward to working with your family.

Yours truly,

Initial Service Coordinator, The Family Connection, WIHD

Tel#: ________________________________
EARLY INTERVENTION PROGRAM INTAKE

CHILD’S NAME:__________________________________________ DOB:____________________

AGENCY:_____________________________________________ INTAKE DATE:_______________

INITIAL 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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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?
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
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. __________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
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: _____/_____/_______
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
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 County Department of Health
Early Intervention Program Medical Form

Child’s Name: __________________________ Date of Birth: ______________

Parent’s Name: __________________________

Address: ________________________________

Immunization History:

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Birth – 2 Months</th>
<th>4 Months</th>
<th>6 Months</th>
<th>12-18 Months</th>
<th>18-24 Months</th>
<th>24-30 Months</th>
<th>30-36 Months</th>
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</thead>
<tbody>
<tr>
<td>(DtaP) Diphtheria, Tetanus, Pertussis</td>
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<tr>
<td>(IPV) Polio</td>
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<tr>
<td>(Hib) Haemophilus influenza type b</td>
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<tr>
<td>(Hep B) Hepatitis B</td>
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<tr>
<td>(MMR) Measles, Mumps, Rubella</td>
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<tr>
<td>(PCV) Pneumococcal Conjugate</td>
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<tr>
<td>Chickenpox) Varicella )</td>
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</tbody>
</table>

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
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.

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. 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.

**You** may request that the documents be destroyed earlier by submitting a request in writing to:

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

[EarlyIntervention@WIHD.org](mailto:EarlyIntervention@WIHD.org)

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, Revised 3/2023
Parental Consent to Use E-mail to Exchange Personally Identifiable Information

Parent’s Name: ____________________________________________
E-mail Address: ____________________________________________
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, _____________________________________, 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. Early intervention team members who I give permission to use unencrypted e-mail to communicate with each other about my child include:

(1) ___________________________ with the e-mail address _____________________________
(2) ___________________________ with the e-mail address _____________________________
(3) ___________________________ with the e-mail address _____________________________
(4) ___________________________ with the e-mail address _____________________________
(5) ___________________________ with the e-mail address _____________________________

Parent’s Signature ________________________________________   Date _________________