

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/Ethnicity: _____
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? _____

