WESTSIDE REGIONAL CENTER

Intake Application for Infants and Toddlers under 3 Years of Age

This application is to assist Westside Regional to determine eligibility for the California Early Start Program. Families whose infants or toddlers have a developmental delay or disability or an established risk condition with a high probability of resulting in a delay may be eligible to receive "Early Start" in California. Teams of service coordinators, healthcare providers, early intervention specialists, therapists, and parent resource specialists evaluate and assess infants or toddlers and provide appropriate early intervention and family support services for young children from birth to three years of age.

Eligibility for Early Start is based on an infant or toddler having one or more of the following conditions:

1. A one-third delay in one or more areas of development before 36 months
2. An Established Risk condition. This is a diagnosed medical condition which has a high probability of resulting in a developmental delay, and/or disability
3. High-Risk for developmental disability due to a combination of two or more risk factors.

To determine your child's eligibility, Westside Regional Center will complete evaluations to assess your child's developmental level. This may consist of a developmental evaluation, and for children older than 18 months, a speech and language evaluation. Additionally, a review of your child's medical history/records is required to clarify and medical or high risk eligible conditions.

This application contains the necessary forms required for Westside Regional Center to initiate the evaluation process. Early Start eligibility determination may take up to 45 days.

To begin the process, complete the application as follows:

1. Complete application (pages 2 to 4) as accurately as possible. The collection of the information on this application is required by the State of California, Department of Developmental Disabilities.
2. Sign the consent for evaluation and services. The evaluation process cannot begin prior to receipt of your written consent.
3. Print out, sign, and submit the entire application and the consent form to WRC's Early Start Intake Department.

To submit your application, choose one of the following:

1. Scan the documents and send them as an EMAIL ATTACHMENT to IntakeUnder3@westsiderc.org
2. Fax the documents to (310) 258 4059
3. Mail the documents to Westside Regional Center, Intake Under Age 3, 5901 Green Valley Circle, Suite 320, Culver City, CA 90230
4. Drop all documents off with the receptionist at Westside Regional Center.

Thank you for your interest in the Early Start Program at the Westside Regional Center. Application questions can be addressed to Sonia Garcia at (310) 258 4120. You can also find more information about California's Early Start Program at www.dds.ca.gov/EarlyStart.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS.

WESTSIDE REGIONAL CENTER Early Start Application
Infants and Toddlers Under Three Years of Age

Child's Information: Please provide complete information about the child being referred.

First name _____Middle name_____ Last name_____

Birth date_____Age in months_____Birth place_____Gender □ Male □Female

Primary language for communication_____ Other languages spoken_____

Ethnicity_____Social Security Number_____

Who does the child live with? □ Both Parents □Mother Only □Father Only □Foster Parents □Caregivers_____
(specify)

Address_____

_____

Mother's Information				Father's Information			
First Name		MI		First Name		MI	
Last Name				Last Name			
AKA or Maiden Name				AKA			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Email				Email			
Home	( )			Home	( )		
Work	( )			Work	( )		
Cell Phone	( )			Cell Phone	( )		
Primary Language				Primary Language			
Birthdate (mm-dd-yyyy)				Birthdate (mm-dd-yyyy)			
Disabled:	Y / N	Date:		Disabled:	Y / N	Date	
Deceased:	Y / N	Date:		Deceased:	Y / N	Date	
Marital Status	□Married □Single	□Divorced □Widower	□Separated	Marital Status	□Married □Single	□Divorced □Widower	□Separated

List all family members, including yourself, who live with the child:

Name Relationship Date of birth

_____

_____

_____

_____

Who is the primary legally responsible party that can be contacted regarding the child's application?
Name Relationship Phone number Email

_____

Please provide information regarding the individual, agency, or office that made referral.
Name of Agency/Contact Person Phone Number Fax/Email

_____

Has this child received assessment or any services from another regional Center? □ Yes □ No
If "yes", please name the regional center_____

Insurance: Please check all that apply, include plan name and bring all benefit cards to your appointment.

☐ Medi-Cal #: _____ ☐ HMO _____ ☐ Fee for Service
(plan name)

☐ Private Insurance: _____ ☐ HMO _____ ☐ PPO _____
(plan name) (plan name) (plan name)

Medical History

Birth weight_____Gestation_____Any neonatal intensive care unit or birth complications? □ Yes □ No
Please describe any birth complications:_____

_____

Does the child have any medical diagnoses/conditions? □ Yes □ No Does the child have a visual impairment? □ Yes □ No
Please describe the impairment_____

Please describe your child's best qualities_____

_____

Please describe your primary concerns with the child's development.

Language Development

How many words does the child have?_____ Does the child combine words? □ Yes □ No
List age (in months) the child could say single words_____ Has the child lost speech? □ Yes □ No
Does the child understand &follow commands? □ Yes □ No Has the child's hearing been tested? □ Yes □ No
Does the child respond to his/her name? □ Yes □ No Results of the hearing test? □ Pass □ No pass
Please describe any concerns_____

_____

Physical Development

List age in months the child could do the following: Roll over_____Sit without support_____Crawl_____
Pull self to stand_____Walk by Holding Furniture_____Walk without support_____

Please describe any concerns_____

_____

Social/Behavioral Development

Please describe any concerns about the child's social interactions and/or behavior_____

_____

Clinician Contact Information for Medical Record Request: Please indicate the name and contact information for the child's birth hospital or NICU, current physician, and/or other medical specialists.

Name of the Birth Hospital/Neonatal Intensive Care Unit (NICU)_____

Address_____

_____

Phone Number_____

Current Physician				**Other Physicians/Specialists** (e.g. neurologist, geneticist)			
First Name		MI		First Name		MI	
Last Name				Last Name			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Phone #	( )			Phone #	( )		
Fax #	( )			Fax #	( )		
Email				Email			
Specialty				Specialty			

Other Physicians/Specialists (e.g. neurologist, geneticist)				**Other Physicians/Specialists** (e.g. neurologist, geneticist)			
First		MI		First		MI	
Name				Last			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Phone #	( )			Phone #	( )		
Fax #	( )			Fax #	( )		
Email				Email			
Specialty				Specialty			

Name of Child_____Date of Birth_____

Parent Signature_____Date_____

Completed application and all accompanying documents can be:
emailed to IntakeUnderAge3@westsiderc.org, faxed to (310) 258 4059, mailed to Westside Regional Center, Intake Under Age 3, 5901 Green Valley Circle, Suite 320, Culver City, CA 90230, or dropped off with the receptionist at Westside Regional Center. Application questions can be addressed to Sonia Garcia at (310) 258 4120.

WESTSIDE REGIONAL CENTER

Parents Consent for Assessment

Child _____ Birth Date _____ UCI # _____

Primary Language of the Home _____ Agency _____ Date _____

Consent for Assessment

Dear Parent or Guardian:

An individual evaluation to determine whether your child needs to begin or continue receiving early intervention services from agencies participating in the Early Start Program is needed. The assessment will help to identify your child's strengths and areas of need. The assessment may include: 1) observation of your child at home or other appropriate settings; 2) an interview with you; 3) review of medical and other reports you agreed to share; and 4) examination using a Denver II Screening or Bayley II Skills test.

The assessment may be conducted in any or all of the following areas:

- ☒ Cognitive development
- ☒ Physical development, including a recent vision, hearing and heath status
- ☒ Communication development (expressive and receptive language)
- ☒ Social/Emotional development
- ☒ Adaptive development

☒ Family Needs Assessment: *The Individual Family Service Plan (IFSP) is required, with the concurrence of the family, to include a statement of the family's concerns, priorities and resources related to enhancing the development of the child.*

Assessment May Be Completed by:

☐ Psychologist (PS)	☐ Teacher (T)	☒ Physical Therapist (PT)
☒ Speech and Language Specialist (SL)	☒ Hearing Impaired Specialist (HI)	☒ Occupational Therapist (OT)
☐ Teacher for the Visually Impaired (VI)	☐ Nurse (N)	☐ Orientation/Mobility Instructor (OM)
☐ Community Mental Health (CMH)	☐ Physician (P)	☐ Early Intervention Specialist (EIS)

☐ Other (specify): _____

☒ *I consent to an evaluation/assessment of my child for purposes of determining eligibility and/or determining early intervention needs.*

☒ *I consent to a Family Needs Assessment. This information will be included in the IFSP to help identify family priorities, needs and* resources related to my child.

I understand that the results will be kept confidential and that I will be invited to attend the IFSP meeting to discuss the assessment results. It is also my understanding that no services will result without my written permission.

Signature of Parent or Guardian: _____ Date _____

IFSP Team Member _____ Position _____

Agency _____ Telephone Number: _____

Address _____ City _____ State _____

Should you have questions regarding this assessment, do not hesitate to call the above named person.