

Colorado's Early Intervention Referral Status Update



Date: _____

Child's Name: _____ DOB: _____

Parent's Name: _____ Date Referred: _____

This child was referred for services and supports. The following is a summary of the status of that referral:

(This status update is the 1st Update 2nd Update 3rd Update 4th Update _____ Update)

A Service Coordinator/Wraparound Facilitator/Case Manager has been assigned to the family:

Name: _____ Agency: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

Repeated attempts have been made to contact this family.

Please let us know if the family is still interested in having an evaluation for their child.

The family has been contacted and requests that you contact them directly for results.

NOTE: The parent(s) or legal guardian must sign a *Consent to Share* form in order to send the information shown below to the referral source.

The family has been contacted and the following has occurred:

The child has been evaluated and found to be **not eligible** for services at this time.

The child has been evaluated and found to be **eligible** for services based on the following information:

An Individualized Family Service Plan (IFSP) has been developed with the child and family (a full copy of the plan may be obtained through the contact listed above).

The child and family are receiving the following early intervention services:

- | | |
|---|--|
| <input type="checkbox"/> Assistive Technology _____ x _____ | <input type="checkbox"/> Psychological Services _____ x _____ |
| <input type="checkbox"/> Audiology Services _____ x _____ | <input type="checkbox"/> Respite Care _____ x _____ |
| <input type="checkbox"/> Developmental Intervention _____ x _____ | <input type="checkbox"/> Service Coordination _____ x _____ |
| <input type="checkbox"/> Health Services _____ x _____ | <input type="checkbox"/> Social/Emotional Intervention _____ x _____ |
| <input type="checkbox"/> Occupational Therapy _____ x _____ | <input type="checkbox"/> Speech Therapy _____ x _____ |
| <input type="checkbox"/> Nutrition Services _____ x _____ | <input type="checkbox"/> Transportation _____ x _____ |
| <input type="checkbox"/> Physical Therapy _____ x _____ | <input type="checkbox"/> Vision Services _____ x _____ |

The child and family have been connected with the following community programs/agencies:

- | | |
|--|--|
| <input type="checkbox"/> CASA – Court Appointed Special Advocate | <input type="checkbox"/> GAL – Guardian ad Litem |
| <input type="checkbox"/> Colorado Child Care Assistance Program (CCCAP) | <input type="checkbox"/> Health Care: _____ |
| <input type="checkbox"/> Court: _____ | <input type="checkbox"/> Health Care for Children with Special Needs (HCP) |
| <input type="checkbox"/> Dept. of Health & Environment Program(s): _____ | <input type="checkbox"/> Hospital: _____ |
| <input type="checkbox"/> Dept. of Human Services Program(s): _____ | <input type="checkbox"/> Mental Health Services: _____ |
| <input type="checkbox"/> EPSDT / Medicaid | <input type="checkbox"/> Private Behavioral Health Therapist: _____ |
| <input type="checkbox"/> Early Head Start/Head Start | <input type="checkbox"/> Project BLOOM |
| <input type="checkbox"/> Educational Program/School District: _____ | <input type="checkbox"/> Social Security Administration |
| <input type="checkbox"/> Faith Partners: _____ | <input type="checkbox"/> Domestic Violence Prevention Program |
| <input type="checkbox"/> Family Support Program: _____ | <input type="checkbox"/> WIC – Women Infants and Children |
| <input type="checkbox"/> Family Voices | <input type="checkbox"/> Waiver Program _____ |
| <input type="checkbox"/> Financial: _____ | <input type="checkbox"/> Other: _____ |

The family will be discussing these services with you in order to obtain authorization to bill insurance, if necessary.

The evaluation/assessment and service planning process has not been completed because _____

If you need additional information, please call the service coordination contact listed above.