This section is Official Use only (IS to copy section to email body): This form is for parent(s) use. V1-10-2018.

| 45 Day | IS Initials | Process Date | UCI | Last Name | First Name | MO | Language | Co | City/Zip(SF) | HR | Date Assigned | SC Assigned |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

# Golden Gate Regional Center – Early Start Parent Intake Form

| Date of Referral: | Child's LAST Name: | Child's FIRST Name: | Date of Birth: =0m | Sex: |
|---|---|---|---|---|
| Child referred to GGRC by what agency, or which professional (MD, ST, OT, PT, School, etc)? | | Referrer's Phone # / Fax # / Email: | | |
| Parent(s) Name: ☐ Married ☐ Separated/Separating ☐ Foster Parent | | Language(s) Spoken in House: | Child's Ethnicity: | |
| Contact Phone #: | Contact Email: | Child's Insurance Provider | | |
| Child's Physical Address: ☐ Check if mailing address is different (and list below) ☐ Transient | | | Birth Hospital: | |
| Therapist/Professionals/Agencies involved (e.g. CPS, ST, OT, PT, CCS, ABA) & Contact Person: | | | Primary Care Physician/Group: | |

## Early Start Services

To be eligible for GGRC Early Start services, any child must be **(1)** within 0-36 months old; **(2)** currently having a development delay, or a diagnosis that will lead to delay.

## If your child is over 3 year old, or close to 3 (34 months+)

School district provides ST/OT/PT after 3. If for concern about developmental disability, call GGRC at (888) 339-3305.

## Annual Family Program Fee (Assessed by CA State)

If a child is eligible and, is receiving services beyond assessment and case management, there may be a fee ($0-200 yearly) assessed by the State of California. Fee is waived for children with Medi-Cal coverage, or low income family (<400% federal poverty level).

Details: http://www.dds.ca.gov/annualfamilyprogram/

| **Your priority/main area of concern? What service are you seeking?** | |
|---|---|

## Speech Concern

| | |
|---|---|
| Hearing Test/Screen | ☐ Newborn Hearing Screen – Outcome:<br>☐ Audiology – Date: -- Outcome: |
| Words and Signs (current) | Number of Clear words #: Did your child ever lost majority of words?<br>Number of Unclear Words #: Does your child use gestures to communicate? |
| Phrases and Sentences | Maximum number of words your child can put together:<br>Example of phrase(s): |
| Responsiveness | Does your child respond well to command, or to his/her name? |
| Eye contact | Does your child maintain eye contact well when she is being talked to? |

## Motor Concern

Please check all that your child is **able** to do/apply:

☐ Sit without support ☐ Crawl ☐ Pull to stand ☐ Stand without support ☐ Walk

☐ Muscle floppiness ☐ Muscle stiffness

If needed, elaborate additional motor concern:

| **Additional comments/diagnosis or concern(s) in other areas of development:** | |
|---|---|

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**To refer via Email –** Send email with subject "Early Start Parent Referral" AND attach this **(1)** referral form, **(2)** all related evaluation reports detailing diagnoses (e.g. ST/OT/ABA), **(3)** Medical Insurance card.

**To refer via Fax –** Fax#: (888) 339-3306