Early Intervention

CHILD & FAMILY CONNECTIONS #16

Serving Champaign, Ford, Iroquois, Livingston, McLean and Vermilion Counties

Phone: 800-877-1152 Fax: (217) 442-8153

EI Number: _____

Child/Family Con. Number: _____

LSA Number: _____

I. CHILD'S INFORMATION

Name: _____ (Last) (First) (Middle)

*AKA: _____ (Also Known As)

*Address: _____

*County: _____

*Date of Birth: / /

*Gender: ☐ Male ☐ Female

*Race: _____

*Hispanic/Latino Origin _____

*Language: _____

*Living Arrangement: _____

*Social Security #: _____

	Yes	No	Pending
*Receiving SSI?	☐	☐	☐
*Medicaid Eligible?	☐	☐	☐

*IDPA Recipient # _____

US Citizen	Yes	No
Child	☐	☐
Parent	☐	☐

Illinois Resident		
Child	☐	☐
Parent	☐	☐

Primary Care Physician: _____

II. REFERRAL SOURCE

Name/Agency: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Reason for Referral: _____

*Referral Sources

☐ Ed. Agency ☐ LIC ☐ Physician

☐ Hosp. Diag. Prog. ☐ Parent/Relative

☐ Health Nurse ☐ Social Service

☐ Other

Code/Description

Type of Referral:

☐ Written ☐ Verbal/Telephone

Family has been informed of referral:

☐ Yes ☐ No

III. PRIMARY CONTACT FOR SCHEDULING APPOINTMENTS

* Name: _____ (Last) (First) (Middle)

* Address: _____

* Home Phone: _____

* Time to Call: _____

* Work/Alternative Phone: _____

* Relationship to Child _____

* Language: _____

	Yes	No
* Legally Responsible	☐	☐
* Financially Responsible	☐	☐

* Social Security #: _____ (If financially responsible)

Referral Completed By: _____ Date of Referral: _____

* Initial Service Coordinator: _____

Cornerstone Entry By: _____ Date: _____ IFSP Due: _____

*Denotes part of electronic record