NYEIS Child

Reference#\_\_\_\_\_\_\_

NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF EARLY INTERVENTION

**Written Notification and Opt-Out Requirements and Timeline**

**Parent Form**

Transition

Tool Kit Item 6

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Early Intervention Program (Part C ) under the Federal Individual with Disabilities Education Act is required to release limited contact information (parent’s name, address, telephone numbers, child’s name, date of birth, and date of referral to the Early Intervention Program) as a way to notify your local school district of your child’s potential eligibility for preschool special education programs and services when your child turns 3 years old. This notification is beneficial in preparing the school district of your child’s eligibility for special education preschool programs and services.

At least 120 days prior to your child’s potential eligibility for services under Section 4410 of Education Law, your service coordinator must provide written notification to the Committee on Preschool Special Education (CPSE) of the local school district in which an eligible child resides of the potential transition of your child.

A parent may opt-out (object) to the written notification and not have the limited contact information sent to the CPSE. The parent must inform the service coordinator, orally or in writing, within 30 calendar days from the date of this notice that the parent chooses to opt-out of the written notification requirement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ I have been informed of the notification requirement and the 30 calendar day timeline to opt-out of the written notification. I am in agreement with sending the written notification and choose to waive the 30 calendar day opt-out period.

OR

\_\_\_\_ I have been informed of the notification requirement and understand I have 30 calendar days from today’s date to opt-out of the written notification. I am aware that if I do not contact my service coordinator, orally or in writing, within 30 calendar days of today’s date, written notification will be sent to the CPSE of my local school district.

OR

\_\_\_\_ I have been informed of the notification requirement and choose to opt-out of the written notification being sent to the CPSE of my local school district.

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



To be filled out by the service coordinator

Parent objected to the written notification to the CPSE. Service coordinator received oral/written objection on:

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No parent objection received within 30 calendars days. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 9/13

NYEIS Child

Reference#\_\_\_\_\_\_\_

NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF EARLY INTERVENTION

**NOTIFICATION OF POTENTIAL ELIGIBILITY TO THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION**

Transition

Tool Kit Item 7

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | DATE OF NOTIFICATION TO CPSE: | | Date of Referral to the EIP: | |
|  |  |  |  |  |
|  | Child’s Name: |  | Child’s Date of Birth: |  |
|  | Last: | First: | Child’s Age (year-month): | |
|  |  | |  |  |
|  | Name of Parent/Legal Guardian/Surrogate: | | Phone No. |  |
|  | Last: | First: |  |  |
|  |  |  |  |  |
|  | Home Address: |  | School District: |  |
|  |  |  | County: |  |
|  |  |  |  |  |
|  | Service Coordinator: |  | Phone No. | Fax No. |
|  |  |  |  |  |
|  | CPSE Chairperson: |  | Phone No. | Fax No. |
|  |  |  |  |  |

Dear Chairperson,

The child named above is potentially eligible for preschool special education services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Coordinator Date

For children in the care and custody or custody and guardianship of the commissioner of the local social services district, the early intervention service coordinator shall notify the local commissioner of social services or designee of the child's potential transition.

Caseworker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Copy of this notification mailed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 9/13

NYEIS Child

Reference#\_\_\_\_\_\_

NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF EARLY INTERVENTION

**CONSENT FORM FOR TRANSITION CONFERENCE**

Transition

Tool Kit Item 8

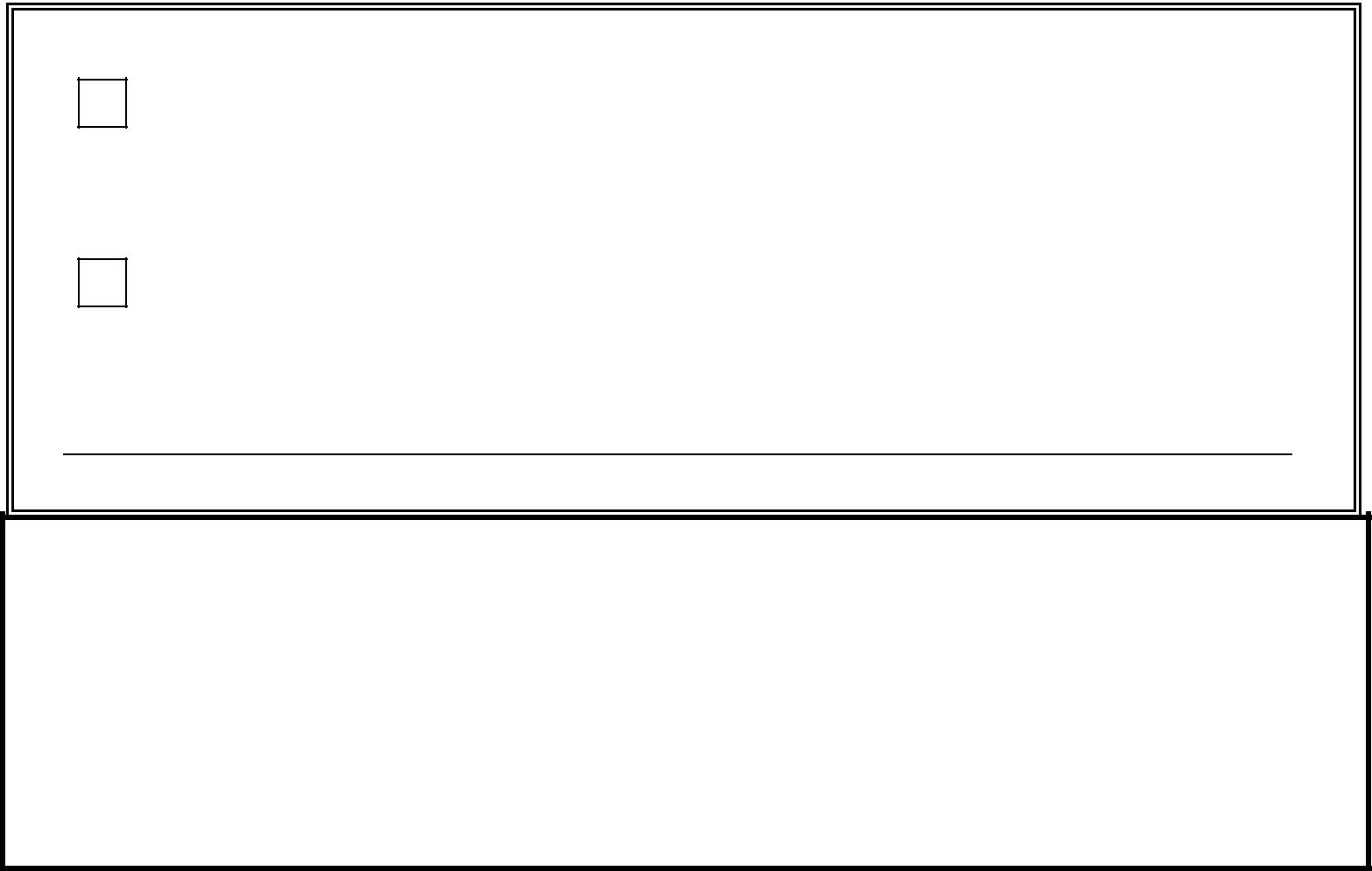
|  |  |  |  |
| --- | --- | --- | --- |
| DATE: |  | Date of Referral to the EIP: | |
|  |  |  |  |
| Child’s Name: |  | Child’s Date of Birth: |  |
| Last: | First: | Child’s Age (year-month): | |
| Name of Parent/Legal Guardian/Surrogate: | | Phone No. |  |
|  |  |  |  |
| Home Address: |  | School District: |  |
|  |  | County: |  |
| EI Service Coordinator: |  | Phone No. | Fax No. |
|  |  |  |  |
| CPSE Chairperson: |  | Phone No. | Fax No. |
|  |  |  |  |

Please Read

**I understand that to ensure my child continues to receive services on and after his/her third birthday, s/he must be referred to, evaluated by, and, before his/her third birthday, found eligible for preschool special education services by the Committee on Preschool Special Education of my local school district (the district in which child resides).**

I understand that as of my child’s third birthday, my child will no longer be eligible for the Early

Intervention Program unless s/he has been found eligible for preschool special education programs and services. **EIP services will end the day before my child turns three years old**.



**CONSENT TO CONVENE A TRANSITION CONFERENCE**

**I give my consent to my Early Intervention Program service coordinator** to arrange atransition conference, which will include my service coordinator, and chairperson of the CPSE or his/her designee, to discuss my child’s referral to the CPSE, program and service options, and develop a transition plan. I also consent to the following agency(ies) or individual(s) attending:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I do NOT wish to have my Early Intervention Program service coordinator convene a transition conference. I understand that my child can be referred to the CPSE without a conference. I understand that my child must be referred to, evaluated by, and, before the day s/he turns three years of age, be found eligible by the CPSE for services, to continue to receive Early Intervention Program services on and after s/he turns three years of age.

Parent Name Parent Signature Date

**CPSE Chairperson**: This notice serves as an invitation to the CPSE Chairperson/Designee to the EarlyIntervention Transition Conference to be held on:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your availability and fax back to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You will participate by: \_\_\_phone \_\_In person \_\_\_\_Not able to attend

cc: The Local Social Services Commissioner/Designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(for children in the care and custody or custody and guardianship of the local social services commissioner)

Revised 9/13

NYEIS Child

Reference #\_\_\_\_\_

NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF EARLY INTERVENTION

**FORM FOR PARENT REFERRAL TO THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION**

Transition

Tool Kit Item 9

|  |  |  |  |
| --- | --- | --- | --- |
| DATE OF REFERRAL TO CPSE: |  | Date of Referral to the EIP: | |
|  |  |  |  |
| Child’s Name: |  | Child’s Date of Birth: |  |
| Last: | First: | Child’s Age (year-month): | |
| Name of Parent/Legal Guardian/Surrogate: | | Phone No. |  |
| Last: | First: |  |  |
| Home Address: |  | School District: |  |
|  |  |  |  |
| EI Service Coordinator: |  | Phone No. | Fax No. |
|  |  |  |  |
| CPSE Chairperson: |  | Phone No. | Fax No. |
|  |  |  |  |

Please Read

**I understand that to ensure my child continues to receive EI services on and after his/her third birthday, s/he must be referred to, evaluated, and found eligible by the Committee on Preschool Special Education of my local school district (the district in which my family resides) before his/her third birthday.**

I understand that as of my child’s third birthday, my child will no longer be eligible for the EIP unless s/he has been found eligible for services under Section 4410 of the Education Law. **EIP services will end the** **day before my child turns three years old**.



**REFERRAL TO THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION (CPSE)**

I am referring my child to the CPSE of the school district in which my child resides for an evaluation to determine whether s/he is eligible for preschool special education programs and services. I give my service coordinator permission to send this form to the CPSE.

**I do NOT choose** to refer my child to the CPSE of the school district in which my child resides foran evaluation to determine whether s/he is eligible for preschool special education programs and services. I understand that my child must be referred to, evaluated by, and, before the day s/he turns three years of age, be found eligible by the CPSE to continue to receive Early Intervention Program services on and after s/he turns three years of age. **I understand that I may choose to** **refer my child for an evaluation by the CPSE at a later date. I understand that if I choose to refer my child at a later date, I must refer my child within enough time for the CPSE to decide whether my child is eligible for services under Section 4410 of the Education Law by the day before s/he turns three years old if I want my child to continue to receive Early Intervention Program services on and after s/he turns three years of age.**

I want the CPSE Chair/Administrator to invite my EI service coordinator, listed below, to the initial meeting with the CPSE that determines my child’s eligibility.

Parent Name Parent Signature Date

Service Coordinator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 9/13

NYEIS Child

Reference #\_\_\_\_\_

NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF EARLY INTERVENTION

**CONSENT FOR TRANSMITTAL OF EIP EVALUATIONS AND RECORDS**

Transition

Tool Kit Item 10

|  |  |  |  |
| --- | --- | --- | --- |
| DATE: |  | Date of Referral to the EIP: | |
|  |  |  |  |
| Child’s Name: |  | Child’s Date of Birth: |  |
| Last | First | Child’s Age (year-month): | |
| Name of Parent/Legal Guardian/Surrogate: | | Phone No. |  |
| Last | First |  |  |
| Home Address: |  | School District: |  |
|  |  |  |  |
| Service Coordinator: |  | Phone No. | Fax No. |
|  |  |  |  |
| CPSE Chairperson: |  | Phone No. | Fax No. |
|  |  |  |  |

**Please Read**

**I understand that the CPSE may use evaluation reports and other EIP records, which I may choose to share, as part of the CPSE evaluation process. I decide what records to share, if any. If I consent to share these records, the CPSE will review them and will decide if other evaluations are necessary to decide if my child is eligible for preschool special education programs and services. I understand that if the CPSE asks for more evaluations, I will be asked for my consent for the CPSE to evaluate my child. I understand that if I do not consent to evaluations asked for by the CPSE, and my child is not evaluated by the CPSE and is not determined eligible for preschool special education programs and services by my child’s third birthday, EIP services will end the day before my child turns three years old.**



**Consent to Transmit Early Intervention Program Evaluation and Program Records to the CPSE**

**I give my consent to my service coordinator** to transmit the following EIP reports and records to theCPSE of the school district in which my child resides:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I do NOT give consent** to my service coordinator to transmit EIP records and reports to the CPSE of theschool district in which my child resides**. I understand that my child must be referred to, evaluated** **by, and, before the day s/he turns three years of age, be found eligible by the CPSE for services, to continue to receive Early Intervention Program services on and after his/her third birthday.**

Parent Name Parent Signature Date

Revised 9/13