PATIENT INFORMATION FORM

GENERAL INFORMATION

PATIENT NAME: _____ DOB: _____

SEX (circle one): M F SSN _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Dx: _____

MOTHER NAME: _____ DR LIC #: _____

PHONE: _____ CELL: _____ WORK PHONE: _____

EMAIL: _____

FATHER NAME: _____ DR LIC #: _____

PHONE: _____ CELL: _____ WORK PHONE: _____

EMAIL: _____

NEAREST RELATIVE IF UNABLE TO CONTACT YOU: _____ PHONE: _____

EMPLOYER _____ EMPLOYER #: _____

REFERRED BY: _____ PHONE: _____

PHYSICIAN NAME: _____ PHONE: _____

PRIMARY INSURANCE: _____

NAME OF PRIMARY INSURED: _____

ID #: _____ D.O.B. OF PRIMARY: _____

PHONE #: _____ GROUP #: _____

Please describe reason for evaluation:

_____

_____

_____

_____

THERAPY PRECAUTIONS-Please be specific

Does your child have any food allergies? Please list.	Yes	No
If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?	Y	N
Are there any precautions not listed above that we should know about. Please describe.	Y	N

PREGNANCY AND BIRTH HISTORY

	Yes	No	Comments
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe:	Y	N	

2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery.	Y	N	
3. Was labor and delivery normal?	Y	N	
4. Was delivery via C-Section?	Y	N	
5. Did your child experience jaundice?	Y	N	
6. Was there need for oxygen or respiratory assistance?	Y	N	
7. Were there difficulties with feeding?	Y	N	
8. Did your child bottle-feed or breast feed? (Circle one)	-	-	
8. Did your child have difficulties sucking?	Y	N	
9. Number of siblings?			

MEDICAL HISTORY

13. Has your child had any of the following:	Yes	No	Comments
a. Cardiopulmonary Problems	Y	N	
b. Chicken Pox	Y	N	
c. Seizures	Y	N	
d. Frequent Ear infections	Y	N	
e. Excessive vomiting or reflux.	Y	N	
f. Asthma	Y	N	
g. Does your child have vision problems?	Y	N	
h. Does your child have hearing problems?	Y	N	
i. Is your child on any medications? Please list.	Y	N	
j. Please describe any pertinent medical conditions not mentioned above.	Y	N	

GROWTH AND DEVELOPMENT

At what age did child first:

Sit alone_____ Feed self finger foods_____

Crawl (hands & feet)_____ Speak first real words _____

Stand alone _____ Speak first real sentences _____

Walk well _____ Become completely toilet trained_____

SCHOOL HISTORY

School name: _____ Grade: _____

Please describe child's performance at school. What subjects does he/she do well in; what subjects does he/she have difficulty with?

_____

_____

_____

Does child exhibit behaviors at home or school that concern you? Please explain:_____

_____

Parent/Guardian Signature_____ Date: _____

KIDS S.P.O.T.
CONSENT FORM

PATIENT NAME: _____

CONSENT TO

I hereby authorize Kids S.P.O.T., including its employees and agents, to render appropriate outpatient care or telehealth/teletherapy care to the patient named above. I understand the nature of the care, examination or treatment being rendered, as well as the anticipated benefits, alternatives, and risks (if any) of receiving such care, and agree to ask my provider to further explain the benefits, alternatives, and risks (if any) if I have any questions. I acknowledge that no guarantees have been made to me regarding the results of any care, examination, or treatment provided by Kids S.P.O.T., regardless of whether provided in an outpatient or telehealth/teletherapy setting.

RECEIVE SERVICES

I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying Kids S.P.O.T. Moreover, I recognize that teletherapy/telehealth is not appropriate for all health care services, and that if I believe teletherapy/telehealth is not appropriate or preferable for me generally or in a specific situation, I agree to let my provider know immediately so that any alternative options may be discussed. In addition, I recognize and agree that Kids S.P.O.T. may terminate services by notifying me of termination and the reason.

TELEHEALTH PRIVACY/SECURITY

I understand that not all electronic modes of communication are completely secure. Although Kids S.P.O.T. works hard to protect my privacy and personal medical information, the security of any electronic mode of communication and any personal information/images/video therein cannot be guaranteed.

OTHER FORMS

I understand that the terms of this Consent Form are in addition to the terms of all others Kids S.P.O.T.'s intake/new patient forms. Moreover, I understand that such terms that apply to in-person/outpatient services, also apply to all telehealth/teletherapy services. Such forms include the Notice (and Acknowledgement) of Privacy Practices; Health Insurance Assignment of Benefits; and the Statement of Patients' Rights and Responsibilities.

AUTHORIZATION OF EMERGENCY MEDICAL SERVICES

In the event of any medical emergency, I authorize Kids S.P.O.T., to provide or obtain such medical treatment as deemed advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment. Moreover, if you are experiencing an emergency, **dial 9-1-1 immediately**.

RELEASE OF MEDICAL RECORDS

I hereby consent and request copies, if necessary, of my prior medical records be delivered to Kids S.P.O.T., to establish or continue my treatment plan.

I hereby authorize Kids S.P.O.T., to release copies of my medical records, or reports or such portions or summaries thereof as may be relevant, to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordination my plan of treatment and for quality assurance, survey, payment, operations, and accreditation purposes.

MEDICAID / PAYMENT AUTHORIZATION

As a Medicaid patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made to Kids S.P.O.T. on my behalf.

PATIENT'S SIGNATURE

NOTE: this form must be signed by the patient of Kids S.P.O.T. unless the patient is a minor, incompetent, or physically incapable of signing.

I have read and fully understand the content of this form and hereby agree and authorize the foregoing provisions.

As used in this document, the terms "I", "ME", and "MY", include, in addition to the undersigned, the patient named above and others for whom the undersigned had assumed responsibility in engaging Kids S.P.O.T. to provide services to the patient.

_____ _____ _____

SIGNATURE / AUTHORIZED REPRESENTATIVE of PATIENT | RELATIONSHIP to PATIENT | DATE

_____

WITNESS SIGNATURE / PRINT NAME

KIDS S.P.O.T.
STATEMENT OF PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have the right to:

1. Be given information about your rights and responsibilities for receiving outpatient therapy services.
2. Be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
3. Receive a prompt and reasonable response from Kids S.P.O.T. to questions and requests.
4. Be aware of who is providing medical services and who is responsible for your care.
5. Be given information as to that patient support services are available, including whether an interpreter is available if you do not speak English.
6. Bring any person of your choosing to the patient-accessible areas of Kids S.P.O.T. to accompany you while you are receiving outpatient treatment or you are consulting with therapists(s) at Kids S.P.O.T., unless doing so would risk the health and safety of you, other patients, or staff of Kids S.P.O.T., or cannot be reasonably accommodated by Kids S.P.O.T.
7. Know what rules and regulations apply to your conduct.
8. Be given information by Kids S.P.O.T. concerning your diagnosis, planned course of treatment, alternatives, risks and prognosis.
9. Refuse any treatment, except as otherwise provided by law.
10. Be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
11. If eligible for Medicare, to know, upon request an in advance of treatment, whether Kids S.P.O.T. accepts the Medicare assignment rate.
12. Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
13. Receive a copy of a reasonable clear and understandable, itemized bill and, upon request, to have the charges explained.
14. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
15. Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
16. Know whether medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
17. Express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of Kids S.P.O.T. and to the appropriate state licensing agency.

As a patient you have the responsibility to:

1. Give accurate and complete health information concerning your present complaints, past illnesses, hospitalizations, medications, allergies, and any other pertinent items related to your health.
2. Report unexpected changes in your condition to Kids S.P.O.T.
3. Report to Kids S.P.O.T. whether you comprehend a contemplated course of action and what is expected of you.
4. Follow the treatment plan recommended by Kids S.P.O.T.
5. Keep appointments and, when you are unable to do so for any reason, notify Kids S.P.O.T. If your child is sick, please call us to cancel their session 12 to 24 hours in advance. Two no-shows will result in your child's time being canceled.
6. Take responsibility for your actions if you refuse treatment or do not follow the instructions from Kids S.P.O.T.
7. Assure that the financial obligations of your healthcare are fulfilled as promptly as possible. You must inform Kids S.P.O.T. of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do so can result in total patient responsibility for incurred charges.**
8. Follow Kids S.P.O.T. facilities' rules and regulations affecting patient care and conduct.

These rights and responsibilities can be exercised on behalf of a patient by a legal representative if the patient lacks decision-making capacity, is legally incompetent or is a minor.

STATE OF FLORIDA: Department of Children and Families
TO REPORT ABUSE, NEGLECT, OR EXPLOITATION PLEASE CALL TOLL-FREE 1-(800)-96-ABUSE
THIS SERVICE IS AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.

I understand the Statement of Patient's Rights and Responsibilities and I have received a copy of it.

_____ _____
SIGNATURE of CLIENT/CLIENT'S LEGAL REPRESENTATIVE DATE

_____ _____
SIGNATURE of KIDS S.P.O.T. REPRESENTATIVE DATE

KIDS S.P.O.T. - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required to maintain the privacy of your Protected Health Information ("PHI") and provide you with notice of our legal duties and privacy practices with respect to such PHI ("Notice").

We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of our Notice at any time and to make the new notice provisions effective for all PHI that we maintain. If we change the terms of our privacy Notice, the revised Notice will be posted on our website. If you should have any questions or require further information, please contact our Privacy Officer at 954-925-3844.

Acknowledgment of Receipt of This Notice

You will be asked to provide a signed Acknowledgment of Receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. The delivery of your services will in no way depend upon your signed Acknowledgment. If you decline to sign an Acknowledgment, we will continue to provide your services. We will also use and disclose your PHI for treatment, payment and health care operations, when necessary.

How We May Use or Disclose Your Health Information

Except as may be otherwise prohibited by state or federal law, the following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time, except to the extent that we have already relied on the authorization.

Your Financial Information: We collect and use several types of financial information to carry out our business activities. This includes information that you give to us on applications or other forms, such as your name, address, age, and dependents. We keep and share financial records such as insurance coverage and payment history, when necessary, with our employees, affiliates, business associates or others who need it to provide services, to do business, for health care operations, or for other legally allowed or required purposes.

Treatment: We may use or disclose your health information to provide you with medical treatment, services or supplies. The Agency may use your health information to coordinate care within the Agency and with others involved in your care, such as your attending physician and other health care professionals who have agreed to assist the Agency in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate treatment. The Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services or supplies. For example, we may submit a claim to your insurance carrier for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. Your information may be disclosed to one or more intermediaries employed by your plan sponsor including, but not limited to, insurers, pharmacy benefits managers and claims administrators.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, employee review and development activities, review and audit activities, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide. The Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary to provide quality care to all of the Agency's patients. Health care operations include such activities as: -Quality assessment and improvement activities. –Activities designed to improve health or reduce health care costs. –Protocol development, case management and care coordination. -Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment. –Professional review and performance evaluation. -Training programs including those in which students, trainees or practitioners in health care learn under supervision. -Training of non-health care professionals. –Accreditation, certification, licensing or credentialing activities. -Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. –Business planning and development including cost management and planning related analyses and formulary development. –Business management and general administrative activities of the Agency. For example the Agency may use your health information to evaluate its staff performance, combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to Agency staff and contracted personnel for training purposes, use our health information to contact you as a reminder regarding a visit to you.

Business Associates: There may be instances where services are provided to our organization through contracts with third-party "business associates." Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written

contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by applicable federal, state or local law.

Communication with Family, Caregivers, and Close Friends: We may disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if: (1) we obtain your written agreement or provide you with the opportunity to object to the disclosure and you do not object; or (2) we reasonably believe that you do not object to the disclosure.

If you are not present for or unavailable prior to a disclosure (i.e., when we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information under such circumstances, we would disclose only information that is directly relevant to the person's involvement with your care.

Public Health: Consistent with applicable federal and state laws, we may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect, elder abuse, domestic violence or any other form of abuse to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence; (3) to any state agency in conjunction with a federal or state health benefit program; (4) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; (6) to prevent a serious threat to your health and safety or the health and safety of the public or another person; and (7) as required by state law for other public health activities.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Marketing: We may, as permitted by law, use or disclose your health information, as necessary, to provide you with recommendations for alternative treatments, therapies, health care providers or care settings.

Research: We may disclose de-identified information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Fund Raising: We may contact you as part of a fund-raising effort. You have the right to opt out of these communications.

Workers' Compensation: We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

Specialized Government Functions: We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

Law Enforcement Purposes: We may disclose your PHI to the police or other law enforcement officials as required by law or in compliance with a subpoena or court order.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Judicial and Administrative Proceeding: We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Decedents: We may disclose PHI to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement: If you are an organ donor, we may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

As Required by Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

Authorization: We will get your written permission before we use or share your PHI for any other purpose, unless otherwise stated or referred to specifically or generally in this Notice. You are not required to authorize any additional uses or disclosures of your PHI, and you may withdraw any authorization you do provide at any time, in writing. We will then stop using your information for that purpose. If, however, we have already used or shared your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at Kids S.P.O.T, 1 Oakwood Blvd Suite 130-140, Hollywood, Florida 33020.

Right to Request Restrictions: You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction. If, however, you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer, and we must agree to that restriction unless disclosure is otherwise provided by law.

Right to Receive Confidential Communications: You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy: You have the right to inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, supply order history, or payment. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying, postage, and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend: You have the right to ask us to amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspections as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12)-month period, we will charge you a reasonable, cost-based fee for the accounting statement.

Right to Obtain a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

Potential Impact of Other Applicable Law: The HIPAA Privacy Rule generally does not preempt or override state privacy or other applicable laws that provide individuals with greater privacy protections. As a result, state privacy laws that provide for a stricter privacy standard will be followed.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

Privacy Officer
Kids S.P.O.T.
1 Oakwood Blvd Suite 130-140
Hollywood, FL 33020

You may also file a complaint with the secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

I have received the Kids S.P.O.T. 's Notice of Care Privacy Practices and am aware of my rights.

_____ _____ _____
Patient Name Patient Signature Date

_____
Family/Significant Other signature (if patient is a minor or judged incompetent)

_____ _____
Relationship Date

_____ _____
Kids S.P.O.T. Representative Date

Director: Annie Bouchereau, MPT/L

Director: Kristina Altieri, OTR/L

HEALTH INSURANCE
ASSIGNMENT OF BENEFITS

Insurance Company _____ Policy No._____

Address _____ Phone_____

Name of Policy Holder _____ SS#_____

Name of Patient _____ SS#_____

Relationship _____ Employer (If Group Insurance) _____

I hereby authorize consent to payment of any insurance or other benefits that may be made on my behalf by my insurer, named above ("Payor"), directly to Kids S.P.O.T. – 7430 W. Commercial Blvd., Lauderhill, FL 33319, for services provided to me (or the Patient if this is signed by an authorized representative).

I understand that this Assignment applies to those eligible charges submitted in connection with services or supplies furnished only by and through the above provider.

I understand that Payor may only cover a portion of the total bill. I understand that I am responsible for all charges not covered or denied, and I agree that if a claim is denied, I am fully responsible for the submitted charges. I understand and agree that Kids S.P.O.T. will bill me for, and I will be responsible for payment of, any copayment and/or balance after Payor's responsibility has ended, or for any charge that is not covered or paid by Payor or any other source. I further understand that I am responsible for any portion of charges, including attorney's fees, interest on unpaid balances, and all costs of collection resulting from investigation necessary to collect any amounts due and owing to Kids S.P.O.T.

I hereby authorize, designate, and assign Kids S.P.O.T. as my (or the Patient's) personal representative to pursue any and all claims arising under State and Federal law (including claims arising under the Employee Retirement Income Security Act of 1974 (ERISA)) and further assign all rights and privileges afforded under my (or the Patient's) health benefit plan regardless of the payer source. I understand that this assignment of benefits and claims does not relieve me (or the Patient) of my obligations to pay Kids S.P.O.T. for any charges not covered by this assignment or not paid by insurance or health care benefits.

I authorize Kids S.P.O.T. to disclose any and all written information concerning my treatment to Payor or its designated representative, as well as any other financially responsible party, at the determination of Kids S.P.O.T., for purposes of obtaining reimbursement for services received.

I also acknowledge:

- I agree to participate and assist Kids S.P.O.T. and its designated representatives with any administrative appeal and/or litigation process necessary to collect payment for treatment and services rendered from any third-party payer.
- I understand that this assignment is subject to revocation at any time by me except to the extent that action has been taken in reliance thereto.
- I appoint Kids S.P.O.T. with a limited power of attorney to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from Payor arising under State or Federal law (including an ERISA claim).
- Should there be an overpayment on my account, a refund check will be mailed to the Payor that submitted the overpayment.
- Kids S.P.O.T. shall be entitled to the full amount of its charges without offset or reduction.

By signing below, I acknowledge that I have read and understand this Assignment of Benefits.

_____ _____

Signature of Policy Holder or Policy Holder's Legal Representative Date

early steps
Children's Medical Services

Referring Broward County Children, Birth to 36 Months, for an Early Steps Developmental Evaluation

Children under 36 months of age, whose families or caregivers have a concern about their development, or whose physician / treating professional has identified a developmental concern / or diagnosed a medical condition likely to cause a developmental delay, may be referred to **Early Steps.**

Make a referral by calling ...

FDLRS/Child Find - *(754) 321 – 7200* - Broward County's central intake site for referrals for children with special needs.
It will be a short and simple phone call. You will be asked to provide contact and insurance information and to describe the concerns identified. Your referral will be forwarded to the lead agency for the Broward Early Steps Program, **CHILDREN'S DIAGNOSTIC & TREATMENT CENTER.**

Early Steps Eligibility ...

Children referred to Early Steps due to a suspected developmental delay will be evaluated by a multi-disciplinary team of professionals to assess their age-appropriate functioning. Eligibility standards are established by the state. Children with a *significant delay* in one or more of the following areas are eligible for early intervention services:

- Cognition
- Communication / Feeding
- Physical (gross or fine motor)
- Social / Emotional
- Adaptive / Self-help skills

Children diagnosed by a physician with an established condition likely to result in a developmental delay are automatically eligible for services.

When eligibility has been determined, an Individual Family Support Plan will be developed. This will include goals and strategies for family participation, as well as the recommended level of professional intervention sessions.

What is Early Steps?

Early Steps is a statewide system of early intervention services focused on parent education and coaching. Early Steps connects families with professionals who teach them how to improve the development of their children through activities they can easily use in their daily routines. The strength and success of early intervention is active parent involvement.

Are there any fees for Early Steps services?

Early Steps early intervention services are funded through Medicaid and private insurance and through the federal Individual with Disabilities Education Act. Service coordination, the eligibility evaluation and interventions, as authorized by the Early Steps team, are provided at no out-of-pocket cost to families, regardless of income.

*I acknowledge that I have been made aware of the **Early Steps Program** and advised of the benefits it may offer my child and family. I further acknowledge that it is my responsibility to initiate a referral in order to determine my child's eligibility for services.*

Print Child's Name	*Date*	*Referring Agency*
Print Parent/Caregiver's Name	*Signature*	

children's diagnostic & treatment center