DEAP INITIAL REFERRAL FORM

Developmental Educational Assistance Program

REFERRAL DATE: _____ 1ST CONTACT/SCREEN DATE: _____

	Referral Date:	Service Began:
MT MLST	_____	_____
FES	_____	_____
CWS	_____	_____
CAW	_____	_____
E&D	_____	_____
ADOS	_____	_____

NAME: _____
First M.I. Last

BIRTH DATE: _____

RACE: _____ GENDER ☐ M ☐ F

SOCIAL SECURITY # _____

INSURANCE/MEDICAID: _____

☐ PRIVATE ☐ HMK ☐ HMK PLUS ☐ I H S ☐ HELP

PARENT/GUARDIAN: _____

☐ BIOLOGICAL ☐ ADOPTIVE ☐ FOSTER ☐ OTHER

MAILING ADDRESS: _____ PHONE: _____

PHYSICAL ADDRESS: _____ CELL: _____

CITY: _____ E-MAIL: _____

STATE: _____ ZIP CODE: _____

COUNTY: _____

REFERRED BY:_____ PHONE: _____

ADDRESS: _____ EMAIL: _____

CITY: _____STATE: _____ ZIP CODE: _____ COUNTY: _____

REASON FOR REFERRAL/DESCRIPTION OF PROBLEM: _____

_____

PARENTS NOTIFIED: ☐ Y ☐ N PARENTS QUESTIONS/CONCERNS: _____

_____

PERSON TAKING REFERRAL: _____

ELIGIBILITY: _____ ELIGIBILITY DATE: _____ FSS: _____

REVIEW PANEL DATE: _____ IFSP/OUTCOMES DATE DUE: _____