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: ☐ Audiology – Date: -- Outcome:
Words and Signs (current)	Number of Clear words #: Did your child ever lost majority of words? Number of Unclear Words #: Does your child use gestures to communicate?
Phrases and Sentences	Maximum number of words your child can put together: 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:	

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