



**Child's Name:**

**DOB:**

I, (Parent/Guardian's Full Name) \_\_\_\_\_, authorize the evaluation of my child by New York Therapy Placement Services, Inc. for possible early intervention services. I understand that a Multidisciplinary Team of evaluators will be involved in the process to determine whether my child is eligible for services. I have been informed that I will be involved in my child's evaluation and Individualized Family Service Plan (IFSP) planning, that I will receive the results of all evaluations, and that a copy of all evaluations will be forwarded to the Department of Health Early Intervention Program to assist in the determination of service needs.

**I authorize for the information below to be obtained and released by New York Therapy Placement Services, Inc. (Please initial):**

  X   EI Medical Form & Immunizations  
  X   Multidisciplinary Evaluation  
\_\_\_\_\_ Supplemental Evaluation(s): \_\_\_\_\_

  X   I authorize New York Therapy Placement Services, Inc. to provide my child's Primary Healthcare Provider with a copy of the evaluation summary form & evaluation results.

  X   I authorize New York Therapy Placement Services, Inc. to provide a copy of my child's evaluations with the assigned Ongoing Service Coordinator, Providers, and my school district upon transition into the Committee on Preschool Special Education.

**At this time the Family Assessment was offered and (circle one): Completed / Declined**

**Below is my child's Primary Health Care Provider:**

**Doctor Name:** \_\_\_\_\_ **Office Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**I understand that this release can be withdrawn at any time.**

**Parent/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Relationship to Child:** \_\_\_\_\_

**Evaluators Names:**

**Port Jefferson Station Office**  
Sensory Gym  
& Speech Language Center  
299 Hallock Avenue  
Port Jeff Station, NY 11776  
631-473-4284  
Fax: 631-331-2204

**Farmingdale Office**  
500 Bi-County Blvd – Suite 114  
Farmingdale, NY 11735  
718-264-1640  
212-752 -1316  
Fax: 631-420-8636

**Uniondale Office**  
626 RXR Plaza  
6<sup>th</sup> Floor, Suite 702  
Uniondale, NY 11556  
516-734-6447  
Fax: 631-331-2204

**Queens Office**  
42-05 Francis Lewis Blvd  
1<sup>st</sup> Floor  
Bayside, NY 11361  
212-752 -1316  
Fax: 631-420-8636

Servicing Long Island  
299 Hallock Avenue  
Port Jeff Station, NY 11776  
Telephone 631-473-4284  
Fax: 631-331-2204  
[www.nytps.com](http://www.nytps.com)



Servicing New York City  
500 Bi-County Blvd  
Suite 450  
Farmingdale, NY 11735  
Telephone 516-753-6507  
212-752-1316  
Fax: 631-420-8636  
Email [therapy@nytps.com](mailto:therapy@nytps.com)

## Parental Consent to Use E-mail & Text Messages to Exchange Personally Identifiable Information

Parent's Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

At your request, you have chosen to communicate personally identifiable information concerning your child's treatment by e-mail and text messages without the use of encryption. Sending personally identifiable information by email and text messages has risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail and text messages can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail and text message senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail and text messages sent over the internet without encryption are not secure and can be intercepted by unknown third parties.
- E-mail and text message content can be changed without the knowledge of the sender or receiver
- Backup copies of e-mail and text messages may still exist even after the sender and receiver have deleted the messages.
- Employers and on-line service providers have a right to check e-mail and text messages sent through their systems.
- E-mail and text messages can contain harmful viruses and other programs.

### Conditions

We will use reasonable means to protect the security and confidentiality of email and text messaging sent and received. However, because of the risks outlined, we cannot guarantee the security and confidentiality of text messaging communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. Consent to the use of text messages includes agreement with the following conditions:

- All correspondence to and from a client can be printed and become part of a file.
- Administrative staff may have access to text messages and emails.
- Although our staff will make every attempt to respond promptly, we cannot always guarantee that texts or emails will be responded to within a specific period.
- If there is a delay in response from our staff, it is the client's responsibility to follow up and confirm that the text or email was received and in case of an urgent matter, should use another form of communication to contact our staff.
- The client is responsible for delineating their desire in writing of any information the client does not want sent by text or email.
- The client is responsible for protecting their password or other means of access. We are not liable for breaches of confidentiality caused by a client or third party.

**Parental Acknowledgement and Agreement**

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail and text messages to communicate personally identifiable information.

Nevertheless, I, \_\_\_\_\_

Authorize \_\_\_\_\_,

whose email and phone number are \_\_\_\_\_  
to communicate with me at the following email address or phone number:

\_\_\_\_\_

concerning my child's participation in the EIP (Early Intervention Program), CPSE or CSE, including but not limited to communication regarding service delivery, his/her progress of the IFSP or IEP and any other related matters. I understand that use of e-mail and text messages without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for members of my child's treatment team to communicate personally identifiable information concerning my child with each other using unencrypted e-mail and text messages. Team members to whom I give permission to use unencrypted e-mail and text messages about my child include:

| Name | E-mail address | Phone Number |
|------|----------------|--------------|
|      |                |              |
|      |                |              |
|      |                |              |
|      |                |              |
|      |                |              |

Parent's Signature: \_\_\_\_\_ Date\_\_\_\_\_

## Family-Directed Assessment

Child's Name \_\_\_\_\_  
Last Name First Name Middle Name

Date of Birth \_\_\_\_\_  
MM/DD/YYYY

| Family Member(s) Participating<br>in the Assessment | Other Family Members/Siblings<br>Who Live in the Household With the Child |
|---|---|
| Name  | Name  |
| Relationship to Child                               | Relationship to Child   |
| Name  | Name  |
| Relationship to Child                               | Relationship to Child   |
| Name  | Name  |
| Relationship to Child                               | Relationship to Child   |

As part of your child's Multidisciplinary Evaluation (MDE), you are given the chance to take part in a voluntary family-directed assessment. Your participation can be helpful in determining the concerns, priorities, and resources of your family related to caring for and enhancing your child's development, all of which will inform the potential results of early intervention services. It is not a test of your parenting skills. The family-directed assessment is based on information provided by you and your family in a personal one-to-one discussion with a member of your evaluation team.

The family-directed assessment can also help you to think about what you need most from early intervention services and other community services or supports, for both your child and family. Additionally, it can help you and your Individualized Family Service Plan (IFSP) team plan for your IFSP meeting if your child is deemed eligible for the Early Intervention Program (EIP). All of the information that you share is kept private. You decide what information from the assessment should be included in the evaluation report and discussed at your IFSP meeting.

What questions can I answer before you make a decision about participating in the family-directed assessment?

Please check and sign:

- ☐ Yes, I would like to participate in the family-directed assessment.
- ☐ No, I do not want to participate in the family-directed assessment.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please note:** If the fillable *Family-Directed Assessment Form* includes a Parent/Guardian's electronic signature for consent to participate in the family-directed assessment, **that signature must also include an electronic signature validation marker (available through applications like Adobe Acrobat, DocuSign, etc.) that includes the signature date and time on the form.** If that safeguard is not available, the *Family-Directed Assessment Form* must be printed to allow the parent/legal guardian to sign for consent on the paper copy.

Administering Evaluator's Signature \_\_\_\_\_ Date \_\_\_\_\_

| Do You Need Help With or Need Information About Any of the Following?                          | Please Check Yes or No                                      | Describe |
|--|---|----------|
| Your child's developmental needs   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Information related to your child's developmental delay or disability                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Housing, food, clothing  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Finding employment   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Telephone, technology (i.e., internet connectivity)  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Finding a physician or other specialists   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Finding childcare  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Help for caregivers to have a break (i.e., respite)  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Mental health resources  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Coping with your child's developmental delay/disability  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Helping your child's siblings adjust to having a sibling with a developmental delay/disability | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Equipment, supplies, assistive technology devices (ATDs) and/or services                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Ideas for family/play activities at home or in the community                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Integrating your child into the community and activities                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Meeting with other families in your community  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Modifying your home to assist with activities of daily living for your child                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Family training/education  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |
| Planning for the future; what to expect  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |          |

| What Are Your Priorities, Resources, and Concerns?   | Describe |
|--|----------|
| Waking/Sleep Routines (i.e., Describe how your child lets you know he/she is awake. Describe nap/bedtime routines with your child, can they go to sleep independently?)  |          |
| Feeding/Mealtime Routines (i.e., Describe how your child eats, drinks, lets you know they are hungry, favorite foods, foods that are difficult.)   |          |
| Diapering/Dressing Routines (i.e., Describe how your child does with diapering? Putting on clothes?)   |          |
| Playtime Routines Indoor/Outdoor (i.e., Favorite toys? Enjoys outdoors? Usual play routines, who do they play with?)   |          |
| Bath Time Routines (i.e., Describe bath time with your child.)   |          |
| Errands/Getting Ready to Go Out Routines (i.e., Describe how your child does on outings or during transitions from one activity to another.)   |          |
| Family Time Routines (i.e., How does your family spend time together? What does your family do for fun?)   |          |
| Parent/Child Relationships and Interactions (i.e., Describe how you interact / engage or play with your child.)  |          |
| Resources (i.e., family, extended family, church, WIC, Medicaid, Doctors, SSI, etc. Who are your supports? What programs outside of the EIP are your family involved with? What resources would you like help contacting?) |          |
| Are there any other priorities, resources, or concerns in relation to your child and family that we have not discussed? If yes, please describe.   |          |

Is there any information from the assessment that you do not want included in the evaluation report and discussed at your IFSP meeting? Describe:

Your service coordinator will give you information and resources on other programs and services which can help your family, including services outside of the Early Intervention Program.