Child Reference#_____

OPWDD Tool Kit Item 4

NEW YORK STATE DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM (EIP)

NOTIFICATION OF POTENTIAL ELIGIBILITY TO THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)

DATE OF NOTIFICATION TO OPWDD:	Date of Referral to the EIP:
Child's Name: Last: First:	Child's Date of Birth:
Name of Parent/Legal Guardian:	Phone No.
Home Address:	OPWDD Region:
Early Intervention Service Coordinator:	Phone No.
Early Intervention Evaluator:	Phone No.

Dear OPWDD,

The child named above is potentially eligible for OPWDD services and programs.

_____ _____

Early Intervention Service Coordinator Date

☐ I have been informed of the notification requirement, and I agree that the Early Intervention Program service coordinator will send this written notification to the New York State OPWDD. I give my consent to my Early Intervention service coordinator to send this notification of the potential eligibility of my child for OPWDD services and programs. **I understand that this is not a referral of my child to OPWDD and that a determination of eligibility for OPWDD services will not be established as a result of this notification.**

I have been provided with information on OPWDD services and I understand I may call the OPWDD Info Line at 1-866-946-9733 if I am interested in determining if my child is eligible for OPWDD services.

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Parent/Guardian Name Parent/Guardian Signature Date