Guide to the Early Intervention and Developmental Monitoring Programs

The Early Intervention Program (EIP) offers therapeutic & support services for children up to 3 years of age with developmental needs and their families with a focus on parent coaching. To be referred, children need to meet one or more of the following criteria.

The Children Suspected of Having a Developmental Delay:
- A child with a developmental delay in one or more of the following areas of development:
  - Cognitive
  - Adaptive
  - Social/emotional
  - Physical (including hearing and vision)
- A child with a diagnosed physical or mental condition with a high probability of developmental delay. Examples:
  - Down Syndrome or other chromosomal abnormalities
  - Central nervous system disorders such as cerebral palsy, spina bifida, micro/macrocephaly
  - Fetal alcohol syndrome
  - Central nervous system abnormality following bacterial/viral infection of the brain or head/spinal trauma
  - Extreme prematurity <1000 grams
  - Diagnosed psychiatric conditions such as reactive attachment disorder and emotional/behavioral disorder
  - Hearing and visual impairment

The Developmental Monitoring Program offers support services to children up to 3 years of age who do not have a confirmed or suspected disability but may be at risk for delay. The use of the Ages and Stages Questionnaire (ASQ) provides a very reliable and valid developmental screening tool. The ASQ is designed to educate parents about child development and empower them to understand when and how to ask for further help for their child.

The Children More Appropriate For Developmental Monitoring:
- Risk Criteria
  - Birth weight <1501 grams
  - Gestational age <33 weeks
  - Congenital malformations
  - Prenatal exposure to certain therapeutic drugs with known potential developmental implications
  - Parent concern present but delay not identified
  - ASQ score in “grey range”
  - Growth deficiency/nutritional problems

Other Resources for parents/caregivers
- Parent as Teachers at Hillside Center: (585) 436-0370 x308; Home visits, Developmental screenings, Outreach worker services, Transportation to OB/GYN visits
- Baby’s 1st: (585) 642-0068; Home visits, Transportation, WIC appointments, and Child development education
- U of R Medical Center Social Work Preventative Program: (585) 224-1730; Parental education, Transportation, Daycare coordination, Social work services, Temporary assistance
- Healthy Families Monroe: (585) 325-6101 x206; Homebased counseling, Parental education, Infant mental health framework, ASQ evaluation
- Nurse-Family Partnership: Home visits with an RN, Developmental screenings, Provides education to guide client towards achieving goals
- Building Healthy Children: (585) 275-2991 x276; Support for teen mothers, Outreach workers, Therapy sessions
- Young Women’s Christian Association: (585) 368-2248; Weekly home visits, Support of family well being
Monroe County Early Intervention Program
Referral Form
(585) 753-5437  fax (585) 753-5259

Date: _______________

Name and title of referral source: __________________________________________

Agency Name: ____________________________________________________________

Phone number: ____________________________

Address (include zip code): ________________________________________________

Check one (See criteria on reverse): □ At risk/Developmental Monitoring   □ Early Intervention

Development Screening completed? □ Yes  □ No  If yes, attach copy.

Reason for referral (See EI Referral Guidelines) __________________________________________

Child’s name: __________________________________________ DOB: ____________  Sex: M___F__

Child’s Gestational Age: ____________ Hearing Impaired: □ Yes  □ No

Child’s race: __________________________ Primary Language: ____________

Hispanic: □ Yes  □ No  Speaks English: □ Yes  □ No

Child’s address (include zip code): __________________________________________

Child’s phone number: __________________________ Alternate #: ____________

Child’s school district: ______________________________________________________

Insurance Name: __________________________ Number: ______________________

Health Care Provider: __________________________ Phone: __________________

Address (include zip code): ________________________________________________

Biological mother’s name: __________________________________________ DOB: ____________

Foster parent’s name: __________________________________________ DOB: ____________

Household Members (of child):

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Medical History:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If Child Protective/Foster Care involved, include caseworker name and phone number:

________________________________________________________________________