Rockland County HEALTH

NYEIS Child Reference # _____

EI-TR-05

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CONSENT FORM FOR TRANSITION CONFERENCE

DATE:	Date of Referral to the EIP:
Child's Name: Last First	Child's Date of Birth: Child's Age (year-month)
Name of Parent/Legal Guardian/Surrogate:	Phone No.
Home Address:	School District: County: Rockland
Service Coordinator:	Phone No.: Fax No.:
CPSE Chairperson:	Phone No. Fax No.:

Please Read

I understand that to ensure my child continues to receive services on and after his/her third birthday, s/he must be referred to, evaluated by, and, before his/her third birthday, found eligible for preschool special education services by the Committee on Preschool Special Education of my local school district (the district in which child resides).

I understand that as of my child's third birthday, my child will no longer be eligible for the Early Intervention Program unless s/he has been found eligible for preschool special education programs and services. **EIP services will end the day before my child turns three years old**.

CONSENT TO CONVENE A TRANSITION CONFERENCE

☐ **I give my consent to my Early Intervention Program service coordinator** to arrange a transition conference, which will include my service coordinator, and chairperson of the CPSE or his/her designee, to discuss my child's referral to the CPSE, program and service options, and develop a transition plan. I also consent to the following agency(ies) or individual(s) attending:
_____.

☐ I do NOT wish to have my Early Intervention Program service coordinator convene a transition onference. I understand that my child must be referred to, evaluated by, and, before the day s/he turns three years of age, be found eligible by the CPSE for services, to continue to receive Early Intervention Program services on and after s/he turns three years of age.

_____

Parent Name Parent Signature Date

CPSE Chairperson: This notice serves as an invitation to the CPSE Chairperson/Designee to the Early Intervention Transition Conference to be held on: Date:_____Time:_____Location:_____
Please indicate your availability and fax back to:_____
You will participate by: ___phone ___In person___Not able to attend

cc: The Local Social Services Commissioner/Designee:_____
(for children in the care and custody or custody and guardianship of the local social services commissioner)