

New Town, ND 58763

Office: (701) 627-2458 / Fax: (701) 627-2365



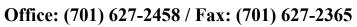
Enrollment Application

For Office Use Only

| Entered Stamp: | Child Plus: ASQ: | | |
|--|--|--|--|
| | Brigance: | | |
| | Technician: | | |
| | | | |
| | nformation quired to be filled out) | | |
| First & Last Name: | | | |
| Gender: Male or Female | DOB: | | |
| Birth Weight: | Weeks Premature: | | |
| Residing Segment: | Ethnicity: | | |
| Enrolled member of a Federally | Is Child Adopted? | | |
| Recognized Tribe? YES or NO | YES or NO | | |
| | Is child currently in foster care? | | |
| Tribal Affiliation: | _ YES or NO | | |
| Francillos and Niversham | List Case Manager: | | |
| Enrollment Number:Referral Source: | Health Insurance: | | |
| Referral Source. | Health insurance: | | |
| Will need proof of Health Ins | urance (if any) & Tribal Enrollment | | |
| | dian Information | | |
| First & Last Name: | | | |
| First & Last Name: | | | |
| Mailing Address: | | | |
| Physical Address: | | | |
| Phone #: | Phone #: | | |
| Best Time to Contact: | | | |
| Email: | | | |
| | | | |
| Early Intervention Specialist Review Initials: | | | |



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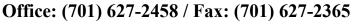




| | Family Informa | tion (Please Circle any that | apply): |
|--|--|--|-------------------------|
| TANF | Medicaid | EBT/Commodities | General Assistance |
| WIC Occupation Status:Employed | First StepsUnemployed | Indian Health Services Highest Level of Education: GradeHS or GED2\ | Other: /R4YRGrad/PhI |
| | Please che | eck any that apply: | |
| Child with a disable Chronic health collaborational and Low Income (Eliging Recent Immigrant Substance Abuse Court Appointed le Homeless or unstable Incarcerated Pare Very low birth weig Death in immediate Domestic Violence Child abuse or new Military Family On Individual Edu | ndition attainment ble for WIC, Food Stamp or refugee family (Foreig (Parent had used or curregal guardians and/or fostable housing nts ght (under 3.3 lbs.) te family (a child, parent, e) glect cation Plan (IEP) of Indiv | os, TANF, Fuel Assistance, GA, ETC gn Born) rently using illegal substances) ster parents | /here? |
| | Med | dia Release | |
| I am giving consent for to be used in any prom Initials: | photographs, videos and | l/or like materials, in which my son/da | aughter may appear – |
| | Exchangeable an | d Release of Information | |
| | | rogram my son/daughter is enrolled & Toddler Program and TAT Head St | |
| Parent/Guardian S | ignature | | Date |
| | Early | Intervention Specialist Review In | nitialo: |



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Screening Notice & Consent

With your permission, the Infant & Toddler Program will conduct a developmental screening to determine any concerns or needs with your child's development. A need for further evaluation may be determined as a result.

Would you like to receive a text /email of your child's next screen? YES or NO

The **ASQ** and **Brigance** screening covers:

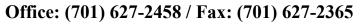
| Gross Motor Skills | Fine Motor Skills |
|----------------------------|---------------------------|
| Visual Motor Skills | Receptive Language Skills |
| Expressive Language Skills | Self – Help Skills |
| Social & Emotional Skills | Speech & Language Skills |

Other forms of screenings (please circle). By request are:

| Hearing & Vision | Autism | | Behavioral Health | |
|--|--------------|-----------------|---------------------|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| l hereby <u>authorize</u> the Infant ઠ | <u> </u> | m to screen r | ny child. | |
| | | | | |
| Child's Name: | | Date of Birth: | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Parent/Guardian Signature | | | Date | |
| | | | | |
| | Early Intony | ontion Speciali | et Poviow Initials: | |



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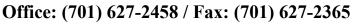


Authorization for Release of Information

| As the legal parent/guardian of: | who's birthdate is:/_ / I hereby |
|--|---|
| authorize the Infant & Toddler Program under the | |
| written information related to evaluations, prograr | 9 |
| progress with the following agencies who may be | · |
| progress with the fellowing agentices who may be | working with my office. |
| Anne Carlson Center | r – Jamestown ND |
| BECEP – Bis | |
| Chatter Pediatric The | • |
| Division of Children's Special He | |
| Elbowoods Memorial Heal | |
| KIDS Human Service C | |
| Mayo Clinic – R | |
| Minot Center of Ped | iatrics – Minot, ND |
| Minot Infant Develop | |
| Northwest Human Service Unit – In | |
| Red Door Pediatric Therapy | |
| Rehab Visions – | <u> </u> |
| Sanford – Bis | · |
| Shriner's Children Ho | • |
| Souris Valley Special S | |
| St. Alexius – B | • |
| TAT Head Start, WIC, Social | |
| Trinity Hospital West Central Human Se | |
| West River Special Ser | • |
| Wilmac Service Un | |
| Other: | W WINDON, IVD |
| | |
| | |
| l, the legal parent/guardian of the child listed abo | |
| used to assist the team(s) in developing and impl | ementing and appropriate program for |
| developmental activities and family support service | ces. This may be withdrawn with a written |
| consent at any time. The authorization to release | information will last until the day the child turns |
| six years of age or moves from the Fort Berthold | Indian Reservation. |
| , . | |
| Parent/Guardian Signature | Date |
| | |
| Early Inter | vention Specialist Review Initials: |
| | |



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The information you provide will help us connect you with the appropriate resources for your child if needed.

Please check the appropriate box I your child has been identified or is suspected of having any of the following:

| | Identified: | Suspected: | Date: | Evaluated by: |
|--------------------------------|-------------|------------|-------|---------------|
| Intellectual Disability | | | | |
| Hearing Impairments | | | | |
| Vision Impairments | | | | |
| Speech/Language Impairments | | | | |
| Emotional / Behavior Disorder | | | | |
| Specific Learning Disabilities | | | | |
| Deaf or Blindness | | | | |
| Autism | | | | |
| Traumatic Brain Injury | | | | |
| Developmental Delay | | | | |
| Other Health Impairments | | | | |
| Allergies | | | | |

| Please check box if parent/guar | dian reports no disability at this time | |
|---------------------------------|---|------|
| | | |
| Parent/Guardian Signature | | Date |
| | Early Intervention Specialist Review Initials | s: |