

Child Action, Inc.

Client Services

Needs Assessment & Referrals

Parent's Name: _____

Child's Name: _____ Child's Age: _____

I. ASSESSMENT

Does your child have an active Individualized Education Program?
(or an active Individualized Family Service Plan) YES NO

Is your child in a special education program? YES NO

Does your child have limited English proficiency? YES NO

Does your child have multiple disabilities (physical or mental)? YES NO

II. REFERRALS

I received the following referral lists in my enrollment packet:

- Health Issues
- Parenting Education/Information
- Services for people with disabilities
- Counseling services
- Food/clothing services

III. CHOOSING CHILD CARE:

Did you interview more than one provider? YES NO

Did you visit your provider before choosing the care? YES NO

Why did you choose the care you did?

Parent Signature

Date