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|  |  WORKFIRST - PUBLIC HEALTH CHILDREN WITH SPECIAL NEEDS INITIATIVE **Special Needs Evaluation and Engagement Recommendations** |
| PARENT/GUARDIAN’S NAME  | JAS IDENTIFICATION NUMBER |
| CHILD’S NAME | CHILD’S BIRTHDATE |
| EVALUATION COMPLETED?[ ]  Yes [ ]  No | IF NO, CHECK APPROPRIATE BOX[ ]  Client refused [ ]  Client not home[ ]  Did not respond to mail [ ]  Did not respond to phone call | DATE OF EVALUATION |
| PRIMARY HEALTH CARE PROVIDER NAME | ADDRESS | PHONE NUMBER (WITH AREA CODE)**(     )** |
| **1. Child’s Information** |
| List the child’s diagnosis and medical condition: |
| Describe the care requirements of the child that affects the parent’s ability to participate in normal daily work related activities. Include the total hours / day and days / weeks. |
| Describe how many hours the child attends school each week and whether an IEP / 504 Behavioral Plan is in place or is needed. |
| List specific services for the child that would provide needed supports to help the parent participate in work or work-like activities: |
| **2. Summary and Recommendations** |
| Given the child’s condition, check the appropriate box:[ ]  The parent can participate 0 – 10 hours per week. [ ]  The parent can participate more than 30 hours per week.[ ]  The parent can participate 11 – 20 hours per week. [ ]  Please contact me for further information.[ ]  The parent can participate 21 – 30 hours per week.How long do you expect the parent will need to provide this level of care:   |
| PUBLIC HEALTH NURSES’S NAME (PRINT) | COUNTY |
| PUBLIC HEALTH NURSE’S SIGNATURE DATE | PHONE NUMBER (WITH AREA CODE) | FAX NUMBER (WITH AREA CODE) |