|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | 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) |