FIRST STEPS
KENTUCKY'S EARLY INTERVENTION SYSTEM

DCBS Referral Form

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Lexington, KY 40504
Phone: 1-800-454-2764
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FS-1B
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DCBS Referral Information

DCBS Office Making Referral:_____
DCBS Caseworker: _____ Date of Referral: _____/_____/_____
Person Making Referral, if not DCBS Caseworker:_____
Address: _____
Office Phone: _____ Office Fax: _____ e-mail: _____

Required Information:

Child currently has an open case with Division of Protection and Permanency (DPP)? ☐ Yes ☐ No

Is the child currently in home or out of home? ☐ In home ☐ Out of home

Legal Status of child:

A) ☐ Parental custody, rights intact

B) ☐ Foster care, biological parent rights intact

C) ☐ Foster care, parent rights terminated

D) ☐ Other/Explain:_____

If B above applies, provide parent contact information:

Name: _____
Address: _____
Home Phone:_____ Other Phone: _____
A foster parent has the authority to make educational decisions on behalf of a child if the parent grants permission in writing.
Has parent agreed to foster parent making educational decisions? Attach parent signed DPP-330 to referral.
NOTE: *DPP caseworkers may not make educational decisions on behalf of the child as this is considered as a conflict of interest under the Individuals with Disabilities Education Act, Part C.*

Parent/Child Contact Information

Child's Name: _____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female Medicaid Card # _____

Child resides with: ☐ Parent ☐ Legal Guardian ☐ Foster Family

Name: _____
Address: _____
How long has child resided at this residence? _____
Home Phone:_____ Other Phone: _____
If family has no phone, contact person: _____
Relationship to child:_____ Phone:_____
Primary Language spoken in the home: _____

Reason(s) for Referral to Early Intervention

First Steps, Kentucky's Early Intervention System, provides developmental intervention services for children ages birth to three. The children qualifying for these services have a significant developmental delay or have medical conditions which put them at risk for significant delays in their development or a disability.

Please Check all suspected areas of developmental delay or concern that apply:

☐ Behavior ☐ Cognitive ☐ Motor/Physical ☐ Social/Emotional ☐ Speech Language
(Describe): _____
_____

☐ Other (Describe): _____
_____

☐ Health Concerns (Describe): _____
_____

Name of Physician: _____ Phone number:_____

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Kentucky Public Health
Prevent. Promote. Protect.