

**NYC EARLY INTERVENTION PROGRAM
CLOSURE FORM**

*(To be used by the service coordinator only when ALL EI services terminate, the child ages out, or when child is found ineligible)**

Child's Name: _____
(Last) (First) Middle

EI ID #: _____ DOB: ____/____/____

Effective Date of Closure: ____/____/____ Date of Submission: ____/____/____

Prepared by: _____ SC ID #: _____
Name of Service Coordinator

Telephone #: (____) _____ Fax: (____) _____

DISPOSITION (Check one)

- | | |
|--|---|
| <input type="checkbox"/> K – Refused prior to IFSP – contact in 2 months | <input type="checkbox"/> B – Parent refused EI services at or after IFSP |
| <input type="checkbox"/> L – Age out, not eligible for 3-5, no referrals | <input type="checkbox"/> D – Transferred to the 3-5 system |
| <input type="checkbox"/> C – Can't locate family | <input type="checkbox"/> M – Age out, not eligible for 3-5, referred to other program |
| <input type="checkbox"/> E – Evaluation/Screening found not eligible | <input type="checkbox"/> A – Delay condition resolved |
| <input type="checkbox"/> N – Age out, eligibility for 3-5, unknown | <input type="checkbox"/> Z – Duplicate |
| <input type="checkbox"/> I – Child died | <input type="checkbox"/> G – Moved out of New York City, specify: |
| <input type="checkbox"/> H – Moved out of state, specify below | |

COMMENTS:

Parent Signature: _____ Date: ____/____/____

Parent was unavailable for signature. Explain above.

Parent was informed of monitoring services:

- J – Transfer to Developmental Monitoring Unit. Risk Factor: _____
- Parent objected to referral for monitoring

Primary Health Care Provider: _____

Address: _____

Telephone #: (____) _____

Reviewed by EI/OD: _____ Date: ____/____/____

Signature

***Note:** The service coordinator must send a copy of this form to the transportation and respite provider when applicable.

EIP Data Entry: _____ Date: ____/____/____