Early Start Application for Infants and Toddlers Under Three Years of Age

Child's Information

First name ________________________Middle name______________ Last name________________________________

Birth date_________________Age in months________Birth place________________Gender ☐ Male ☐Female

Primary language for communication with regional center____

Ethnicity___________________________________Social Security Number_____________________________________

Who does the child live with? ☐ Both Parents ☐ Mother Only ☐ Father Only ☐Foster Parents

Address____

____

Mother's Information				**Father's Information**			
First		MI		First		MI	
Last				Last			
AKA or Maiden Name				AKA			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Email				Email			
Home	( )			Home	( )		
Work	( )			Work	( )		
Cell Phone	( )			Cell Phone	( )		
Primary Language				Primary Language			
Birthdate (mm-dd-yyyy)				Birthdate (mm-dd-yyyy)			
Disabled:	Y / N	Date:		Disabled:	Y / N	Date	
Deceased:	Y / N	Date:		Deceased:	Y / N	Date	

List all family members, including yourself, who live with the child:

Name Relationship Date of birth

____

____

____

____

Who is the primary legally responsible party that can be contacted regarding the child's application?

Name Relationship Phone number Email

____

Please provide information regarding the individual, agency, or office that made referral.
Name of Agency/Contact Person Phone Number Fax/Email

____

Has this child received assessment or any services from another regional Center? □ Yes □ No
If "yes", please name the regional center____

Insurance: Please check all that apply, include plan name and bring all benefit cards to your appointment.

☐ Medi-Cal #: ______________________ ☐ HMO ____________________ ☐ Fee for Service
(plan name)
☐ Private Insurance: ____________________ ☐ HMO ____________________ ☐ PPO __________________
(plan name) (plan name) (plan name)

Medical History

Birth weight______________Gestation_______Any neonatal intensive care unit or birth complications? □ Yes □ No
Please describe any birth complications:____

____

Does the child have any medical diagnoses/conditions? □ Yes □ No Does the child have a visual impairment? □ Yes □ No
Please describe the impairment____

Please describe your child's best qualities____

____

Language Development

Does the child combine words? □ Yes □ No Has the child lost speech? □ Yes □ No
Does the child respond to his/her name? □ Yes □ No Has the child's hearing been tested? □ Yes □ No
How many words does the child have?_________________ Results of the hearing test? □ Pass □ No pass
List age (in months) the child could say single words_______
Please describe any concerns____

____

Physical Development

List age in months the child could do the following:
Roll over_______Sit without support________Crawl________Pull self to stand________Walk without support________

Please describe any concerns____

____

Social/Behavioral Development

Please describe any concerns about the child's social interactions and/or behavior________________________________

____

Contact Information for Medical Record Request

Please indicate the name and contact information for the child's birth hospital or NICU, current physician, and/or other medical specialists.

Name of the Birth Hospital/Neonatal Intensive Care Unit (NICU)____

Address____

____

Phone Number____

Current Physician				Other Physicians/Specialists (e.g. neurologist, geneticist)			
First		MI		First		MI	
Last				Last			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Email				Email			
Work	( )			Work	( )		
Cell Phone	( )			Cell Phone	( )		
Specialty				Specialty			

Other Physicians/Specialists (e.g. neurologist, geneticist)				Other Physicians/Specialists (e.g. neurologist, geneticist)			
First		MI		First		MI	
Name				Last			
ADDRESS				**ADDRESS**			
Street				Street			
City		State		City		State	
Zip Code				Zip Code			
Email				Email			
Work	( )			Work	( )		
Cell Phone	( )			Cell Phone	( )		
Specialty				Specialty			

Name of Child____Date of Birth____________________

Parent Signature____Date___________________________

Completed application and all accompanying documents can be emailed to Sonia Garcia at soniag@westsiderc.org, faxed to (310) 258 4059, mailed to Westside Regional Center, 5901 Green Valley Circle, Suite 320, Culver City, CA 90230 (attention Sonia Garcia), or dropped off with the receptionist at Westside Regional Center.
Application questions can be addressed to Sonia at (310) 258 4120.