NEW YORK STATE DEPARTMENT OF HEALTH

BUREAU OF EARLY INTERVENTION

**NOTIFICATION OF POTENTIAL ELIGIBILITY TO THE**

**OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES**

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| DATE OF NOTIFICATION TO OPWDD: | Date of Referral to the EIP: |
| Child’s Name:  Last: First: | Child’s Date of Birth: |
| Name of Parent/Legal Guardian: | Phone No. |
| Home Address: | OPWDD Region: |
| Early Intervention Service Coordinator: | Phone No. |
| Early Intervention Evaluator: | Phone No. |

Dear OPWDD Regional Coordinator,

The child named above is potentially eligible for OPWDD services and programs.

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Early Intervention Service Coordinator/Evaluator Date

I have been informed of the notification requirement, and I agree that the Early Intervention Program will send this written notification to the above OPWDD regional office. I give my consent to the <Name of County> Early Intervention Program to send this notification of the potential eligibility of my child for OPWDD services and programs. I understand that this is not a referral of my child to OPWDD and that a determination of eligibility for OPWDD services will not be established as a result of this notification.

I have been provided with information on OPWDD services and I understand I may contact the OPWDD regional office if I am interested in requesting an OPWDD eligibility determination.

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Parent/Guardian Name Parent/Guardian Signature Date