Child Action, Inc.
Client Services

Needs Assessment & Referrals

Parent's Name: ____________________________________________________________

Child’s Name: _____________________________________________________________ Child’s Age: _______________

I. ASSESSMENT

Does your child have an active Individualized Education Program?  
(or an active Individualized Family Service Plan)  
☐ YES  ☐ NO

Is your child in a special education program?  
☐ YES  ☐ NO

Does your child have limited English proficiency?  
☐ YES  ☐ NO

Does your child have multiple disabilities (physical or mental)?  
☐ YES  ☐ NO

II. REFERRALS

I received the following referral lists in my enrollment packet:

• Health Issues
• Parenting Education/Information
• Services for people with disabilities
• Counseling services
• Food/clothing services

III. CHOOSING CHILD CARE:

Did you interview more than one provider?  
☐ YES  ☐ NO

Did you visit your provider before choosing the care?  
☐ YES  ☐ NO

Why did you choose the care you did?

_________________________________________________________________________
_________________________________________________________________________
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Parent Signature ___________________________ Date _______________________

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