NASSAU COUNTY DEPARTMENT OF HEALTH
60 Charles Lindbergh Blvd., Suite 100
Uniondale, NY 11553-3683

FAMILY ASSESSMENT

Child's Name_____ Date of Birth_____/_____/_____

1. Why did you refer your child to Early Intervention?
2a. If you need help, who can you ask?
2b. What do you need help with in providing for your child? (For example, health insurance or a pediatrician.)
3a. What areas of your child's development concern you?
3b. What are your immediate priorities in obtaining help for your child?
4. What would you like your child to achieve through the Early Intervention Program?

Completed by_____ Date_____/_____/_____
(Signature and Title)

EI 5171 1/06