

**SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
EARLY INTERVENTION PROGRAM BILINGUAL EVALUATION BILLING**

Child's Name: _____ Date of Birth: _____

Agency: _____ MKSA, LLC _____ Child's EI#: _____

Please check appropriate boxes and complete the information requested:

The core evaluation was performed in the following second language: _____

<i>Type of Evaluation</i>	<i>Date of Evaluation</i>	<i>Name/Title of Evaluator</i>
_____	_____	_____
_____	_____	_____

A supplemental evaluation was performed in the following second language: _____

<i>Type of Evaluation</i>	<i>Date of Evaluation</i>	<i>Name/Title of Evaluator</i>
_____	_____	_____
_____	_____	_____

OR

An *interpreter** was present during the core and/or supplemental evaluation(s) to assist a monolingual evaluator and the family with the evaluation process.

Name of Interpreter _____

AND

The written oral summary of this evaluation was provided to the family in the dominant language or other mode of communication of the parent.

The attached evaluation(s) is (are) to be considered bilingual evaluation(s) in accordance with the following: To the extent feasible and with the parent's preference and consent regarding disclosure to the interpreter, and within confidentiality requirements, the written and oral summary of the evaluation shall be provided in the dominant language or other mode of communication of the parent.

Excerpted from **Sec.69-4.8 (a)(9)(v)Evaluators/Screening, Evaluation and Assessment Responsibilities**

Parent requested evaluation report in English. Parent requested evaluation report in _____
Name of Language

Parent Signature to the Above Choice of Report	_____/_____/_____ Date
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If written report was not feasible, please explain:

*An interpreter interprets the spoken word either from one language to another or to another mode, such as sign language. Family members should not be used as interpreters unless absolutely unavoidable. Additionally, siblings should not be asked to take on the role of explaining a sibling's disability to his/her parent.

Signature/Title of the Person Attesting to the Above	MKSA _____ Agency (if Applicable) of the Person Attesting	_____/_____/_____ Date
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