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: _____
Please list: *Type of Evaluation* *Date of Evaluation* *Name/Title of Evaluator*

_____ _____ _____

_____ _____ _____

[ ] A supplemental evaluation was performed in the following second language: _____
Please list: *Type of Evaluation* *Date of Evaluation* *Name/Title of Evaluator*

_____ _____ _____

_____ _____ _____

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

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.

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