



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Early Start Intake Application

(Infants and Toddlers under 3 years of age)

This application is to assist the North Los Angeles County Regional Center (NLACRC) to determine eligibility for the California Early Start Program. Eligibility for Early Start is based on an infant or toddler having one or more of the following conditions:

- (1) An Established Risk condition. This is diagnosed medical condition which has a high probability of resulting in a developmental delay, and/or disability.
- (2) A one-third delay in one or more area of development before 24 months, or, at 24 months of age or older, either a fifty percent delay in one area or a one-third delay in two or more developmental areas.

If your child is not eligible for Early Start, your child will be considered for California's Prevention Program, which provides developmental monitoring to children birth thru 35 months of age with high risk conditions and certain developmental delays that do not otherwise qualify them for Early Start.

In order to determine your child's eligibility, NLACRC will complete an evaluation to assess your child's developmental level. Additionally, a review of your child's medical history/records is required. This application contains the necessary forms required for NLACRC to initiate the evaluation process. Early Start eligibility determination may take up to 45 days.

Your child's information is confidential and will only be released with your written consent for the purpose of coordinating the evaluation.

To begin the process:

- 1 Do you live in the NLACRC catchment area?
NLACRC serves individuals who reside in the San Fernando, Santa Clarita, or Antelope Valleys of Los Angeles County ONLY. If you do not live in one of these areas, you need to apply for services at the Regional Center that serves the area in which you live, please visit <http://www.dds.ca.gov/RC/RCzipLookup.cfm> to find the Regional Center that serves your Zip code.
2. Please complete the application (pages 1-4) as accurately and completely as possible. **The collection of the information on this application is required by the State of California, Department of Developmental Services.**
3. Please **sign** the consent for evaluation and services on page 5. **The evaluation process cannot begin prior to receipt of your written consent.**
4. Please **sign** medical record releases on pages 6, 7, 8. These releases allow us to obtain medical records and information from your child's hospital and/or physician and are critical to confirm the medical information to establish eligibility for the Early Start program.
5. Please **FAX the entire application with signature pages (Pages 1-8)** to NLACRC intake department **818 756 6357**. The rest of the packet contains notices about the Early Start Program and the privacy of your child's health information. Please read these notices and keep for your records. **DO NOT FAX the notices back to NLACRC.**
6. **You may submit the application by email instead of fax by pressing the submit button at the top of this application or by sending to intake@nlacrc.org. If you are submitting by email, make sure all the signature lines are signed and dated. You may use a digital signature.**
7. You will receive confirmation that your application has been received within 3 business days.
8. SPECIAL INSTRUCTION for DCFS (Department of Children and Family Services) Cases: IN ADDITION to completing the application and signature pages, please also FAX: 5005 Form with reason of referral and Minute Order from the court. Make sure that the consent for evaluation (page 5) is **signed** by the appropriate **legally responsible party with educational rights for the child.**

Thank you for your interest in the Early Start Program at the North Los Angeles County Regional Center. Please visit our website www.nlacrc.org. You can find more information about California's Early Start Program at www.dds.ca.gov/EarlyStart



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Early Start Intake Application

For Children Under 3 Years of Age

Child's Information: Please provide complete information regarding the child being referred.

First Name	Middle Name	Last Name
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date	Birth Place	Gender
Primary Language	Ethnicity	Social Security Number
If the Child's name has been changed, please list previous name below.		
Previous First Name	Previous Middle Name	Previous Last Name

Who does the child live with?	<input type="radio"/> Parents <input type="radio"/> Mother Only <input type="radio"/> Father Only <input type="radio"/> Foster Parents <input type="radio"/> Facility				
Street					
City	State	Zip			

Who is the primary legally responsible party that can be contacted regarding the Child's application?		
First Name	Last Name	Relationship
Primary Phone Number	Alternate Phone Number	Email Address

Please provide information regarding the individual, agency, or office that made referral.		
Name of Agency / Contact Person	Primary Phone Number	Fax / Email

Has the child received assessment or services from another Regional Center? Yes No

If "Yes," please name the Regional Center in the box.

Attention DCFS Only: Please name the individual with educational rights for the Child. This Individual must sign consent for services (Pg 5)		
First Name	Last Name	Primary Phone Number



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Father's Information

Does the Father live with the Child? If, "Yes" please check here.

If the Father's information is unknown please check here.

First Name	Middle Name	Last Name
Birth Date	Birth Place	Language
Street		
City	State	Zip
Phone Number	Social Security Number	
Employer's Name	Job Title	
Disabled <input type="radio"/> Yes <input type="radio"/> No	Deceased <input type="radio"/> Yes <input type="radio"/> No	
Marital Status <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widower		

Mother's Information

Does the Mother live with the Child? If, "Yes" please check here.

If the Mother's information is unknown please check here.

First Name	Middle Name	Last Name (Maiden)
Birth Date	Birth Place	Language
Street		
City	State	Zip
Phone Number	Social Security Number	
Employer's Name	Job Title	
Disabled <input type="radio"/> Yes <input type="radio"/> No	Deceased <input type="radio"/> Yes <input type="radio"/> No	
Marital Status <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widow		



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Medical History (Medical record release is required to confirm information.)

Was the child in a neonatal intensive care unit or were there birth complications? Yes No
Please describe birth weight, level of prematurity, and any complications in the box below.

Does the Child have any medical diagnoses or conditions? Yes No
Does the Child have a visual impairment? Yes No
Please describe in box below.

Please describe your primary concerns with the Child's development.

Language Development

- 1. How many words does the child have? _____
- 2. Does the child combine words? Yes No
- 3. Has the child lost speech? Yes No
- 4. Does the child understand and follow commands? Yes No
- 5. Does the child respond to their name? Yes No
- 6. Has the child's hearing been tested? Yes No

In the box below please describe any concerns about the Child's language development.
Also indicate results of hearing test, if applicable.

Physical Development

List age in months the child could do the following:

Support Head	<input type="text"/>	Roll Over	<input type="text"/>	Sit Without Support	<input type="text"/>
Pull Self To Stand	<input type="text"/>	Walk By Holding Furniture	<input type="text"/>	Walk With Hand Held	<input type="text"/>
Walk Without support	<input type="text"/>				

Please describe any concerns about the Child's physical development in the box below.

Social - Behavioral

Please describe any concerns about the Child's social interaction and / or behavior in the box below.



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Clinician Contact Information For Medical Record Request

Please indicate the name and contact information for the child's birth hospital or NICU, current physician and/ or other medical specialist and then please sign the corresponding consents to obtain current records from these providers on pages 6, 7, and 8.

A. Birth Hospital / Neonatal Intensive Care Unit (NICU)

Name		
Street		
City	State	Zip
Phone Number		

B. Current Physician

Name		
Street		
City	State	Zip
Phone Number	Specialty	

C. Other Current Physician or Medical Specialist (for example, Neurologist, Geneticist, Orthopedic Specialist)

Name		
Street		
City	State	Zip
Phone Number	Specialty	

Insurance Information

	Medi-Cal <input type="checkbox"/>
Insurance Company Name	
Name of Policy Holder	Insurance Policy Number



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CONSENT FOR EVALUATION AND RELEASE OF INFORMATION

Consent for Evaluation and Release of Information: Your written consent is needed before an evaluation can be conducted. Additionally, your written consent is needed to allow your personal information to be released to a regional center vendored service provider for the purpose of coordinating the evaluation. The evaluation will help you and the regional center learn about your child and may include talking with you about your child's development, an observation of your child in the home or other settings, and a review of medical and/or other records. This information will assist the NLACRC in determining your child's eligibility for California's Early Start Program and help us identify the type of early intervention services needed.

For Your Information:

- ◆ Your consent for evaluation is entirely **voluntary** and **may be withdrawn at any time.**
- ◆ The evaluation is required to determine eligibility; without an evaluation services may not be provided.
- ◆ The evaluation will be completed in the primary language of your child and family and in a timely manner.
- ◆ The evaluation will help you to identify your concerns for your child and family.
- ◆ The evaluation will provide information about your child's development.
- ◆ You may request information regarding the evaluation as well as a copy of the results.
- ◆ Your child's and family information is strictly confidential and will only be released with your written consent.
- ◆ No services shall start, change or terminate without written notification or the written consent of the family.
- ◆ You have the right to review and inspect your child's records.
- ◆ You have a right to receive further written information about your rights.

Your child will be assessed in the following areas:

- cognitive development
- speech & language (communication) development
- social or emotional development
- physical/motor development
- adaptive development

PLEASE CHECK THE FOLLOWING STATEMENTS AND SIGN BELOW TO CONSENT FOR EVALUATION

- I agree to evaluation** to help determine if my child is eligible or continues to be eligible for Early Intervention Services. I understand that my consent is voluntary and that I may refuse evaluation services at any time. I understand that my child will not receive early intervention services until eligibility is determined through an evaluation.
- I agree to the release of personally identifiable information** to a regional center vendored service provider for the purpose of referral for evaluation. I understand that this information will include the names of the parents and child, child's date of birth, home address, and telephone number(s).
- I acknowledge** that I was provided a copy of the North Los Angeles County Regional Center **Notice of Privacy Practices** and the **Early Start Initial and Annual Notice: Protecting Your Child's Confidentiality, and Parents Rights and Responsibilities.** I acknowledge that I have read (or had the opportunity to read) and understood the Notices. I understand that I can request a paper copy of the Notices at any time.

By signing this form I agree to the above statements, unless otherwise stated.

Name of Child _____ Date of Birth _____

Parent Signature _____ Date _____



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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR OTHER INFORMATION

To: Attention:

I hereby authorize the above named school, medical practitioner, hospital, clinic, mental health facility and/or designated employees to release school or medical information as indicated below.

Please release medical records and/or other information regarding:

Name: Birth Date:

Release medical information to: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)

DURATION

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date is entered.

REVOCACTION

This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

REDISCLASURE

NLACRC may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

SPECIFY RECORDS

Check the box and initial the type of information to disclose:

- Medical Information:** Birth Records, Office visits, physical examinations, developmental assessments, hospital admission and discharge summaries.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (date)
- School/College and Psychological Services:** AB3632 assessment, case studies, psychological, hearing, speech and language evaluations, most recent IEP transcript and/or cumulative records.
_____ (initial) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (date)

I request that the health information released pursuant to this authorization be used for the following purposes only:
These records will be used by the NLACRC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

Signature of Consumer or Consumer's Legal Representative _____

Date _____

Printed Name _____

Relationship, if signed by someone other than consumer _____



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YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION INCLUDE:

Right to Inspect and Copy your Records

You have the right to request in writing to inspect and copy your PHI in designated record sets. If we deny a request, we will do so in writing giving our reasons and you have the right to have that decision reviewed.

Right to Request Amendments to your Records

If you feel that your PHI is incorrect or incomplete, you have the right to ask in writing that we amend it, stating why we should make the correction or addition. If we deny your request, we will do so in writing giving our reasons, and you may file a written statement of disagreement.

Right to Request Restrictions

You have the right to request in writing a restriction or limitation of our use or disclosure of your PHI. You may request that your PHI not be shared with others, like a family member or friend. However, by law, we do not have to agree to your request.

Right to Request Confidential Communications

You have the right to request in writing that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. When we can reasonably or lawfully agree to your request, we will.

Right to an Accounting of Disclosures

You have the right to request in writing an accounting of our disclosures of your PHI for up to 6 years before your request, but not for disclosures made before April 14, 2003. An accounting does not include disclosures to carry out Treatment, Health Care Operations, Payment, General Notification, Law Enforcement, National Security, and to Correctional Institutions as well as otherwise Mandated by Law. Additionally, an accounting does not include disclosures for which NLACRC had a signed authorization, disclosures to you, your care giver, or persons acting on your behalf.

Right to a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request at any time by contacting the J RCC Coordinator at NLACRC

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. A copy of the current Notice will be posted all NLACRC offices in a clear and prominent location. If we change our Notice, you may obtain a copy of the revised Notice by contacting the HIPAA Coordinator at NLACRC.

QUESTIONS/COMPLAINTS

If you have questions regarding this Notice or our privacy practices, or if you are writing about your PHI, including requests for restrictions on its use or disclosure, or to make a complaint about our privacy practices, please write to the HIPAA Coordinator at NLACRC, 17500 Sherman Way, Suite 170, Van Nuys CA 91406, or call 818-788-1900. If you believe your privacy rights have been violated, you may also notify the Secretary of the Department of Health and Human Services (HHS). You will not be penalized for filing a complaint.



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The North Los Angeles County Regional Center (NLACRC) is mandated by law to maintain the privacy of your Protected Health Information (PHI). PHI is information that identifies you in any form (electronic, written, oral, etc.) collected, created, maintained, or received by NLACRC relating to your past, present or future physical/ mental health or condition. We are required by law to provide you, a NLACRC consumer, with this "Notice of Privacy Practices" explaining our legal duties and privacy practices concerning your PHI. We are also required to abide by the terms of the current version of this Notice. In this Notice, the terms "NLACRC", "we", "us", and "our" refer to the North Los Angeles County Regional Center.

WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING SITUATIONS:

Treatment: We may use and disclose your PHI for the provision, coordination and/or management of health care and related services. For example, we may disclose your PHI to case managers, doctors, health care providers, vendors, business associates, caregivers, family and other persons who are involved in taking care of you, both within and outside of NLACRC.

Health Care Operations: We may use and disclose your PHI for our Operations. For example, activities involving, but not limited to, case management, quality assessment and improvement, risk mitigation, oversight by state and federal agencies, audit, training, and advocacy.

Payment: We may use your PHI to, for example, determine our responsibility to pay for, or to permit us to bill and collect payment for the treatment and health-related services that you receive.

Appointment Reminders and Notification: We may contact you about appointments or provide you with information that may be of your interest.

Public Health Activities: We may share your PHI for Public Health Activities, for example, when related to prevention of disease, injury or disability; for tracking and monitoring of certain medical products.

Judicial Proceedings: We may use or disclose your PHI for Judicial Proceedings, for example, as part of an administrative hearing, in response to an order of a court, or a subpoena.

Law Enforcement: We may share your PHI with Law Enforcement Agencies, for example, to respond to a search warrant or to report a crime.

Research: We may use or share your PHI for research approved by the NLACRC Institutional Review Board, a committee that is responsible, under law, to protect the safety of the participants and the confidentiality of PHI. Such research may also require your specific authorization.

Serious Threat to Health or Safety or Disaster Relief: We may use or share your PHI to prevent serious/ imminent threat to your or another person's health and safety.

National Security: We may share PHI with authorized federal officials for intelligence, and other national security activities authorized by Law.

Coroners, Medical Examiners, Funeral Directors and Organ Donation: We may share your PHI with these agencies, as applicable by law, to allow these individuals to perform their official duties; for example, to identify a deceased person.

Correctional Institutions: If you are under law enforcement custody, we may share your PHI with correctional institutions or law enforcement, as needed, for your health care.

As Mandated by Law: We will share your PHI when otherwise required by law.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. The permission you provide us to use or disclose your PHI may be revoked in writing at any time. If you revoke your permission, this will stop any further use or disclosure of your PHI for the purposes covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. There are stricter requirements for the use and disclosure of certain types of PHI, for example, records about HIV/AIDS, mental health, drug and alcohol treatment. This type of information can only be released in accordance with those stricter laws.

Please Keep For Your Own Records.



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Protecting your Child's Confidentiality: What You Need To Know Initial And Annual Notice

Before a child is evaluated for services in the Early Start program and at least once every year thereafter, we are required to tell you in writing what information we collect about your family and your child and what we do to ensure that this information is kept confidential. The following information is very important to your family.

What information do we keep on file that could be used to identify your child?

We keep on file "personally identifiable" information such as a child's full name, parent's names, child's address, Social Security number or other personal identifiers, and information related to the child's diagnosis, gender, ethnicity, etc.

Where do we obtain information about your child?

Information is gathered from persons or agencies that have referred your child for Early Start services and from you, the parent. With your written consent, information also is gathered from other persons/agencies who know your child. These persons may include doctors, teachers, social workers and specialists from hospitals, Regional Centers, schools, etc.

How do we use the information we have about your child?

We use the information to determine if your child *is* eligible for Early Start services. If your child *is* eligible, we use the information to help plan services. If your child *is not* eligible now, the information will be stored for possible future need re-referral for services before your child is three.

What information do we use to assess your child and to develop the Individual Family Services Plan (IFSP)?

A team of professionals from several disciplines and you, the parent, use information from many resources to assess your child and to develop the IFSP. Medical records and health status reports, information obtained from developmental observations of your child, parent report and interviews, standardized tests or instruments may be used.

Where do we keep information about your child?

The information about your child will be kept *in* the work station of your child's service coordinator or a centralized file room. All personally identifiable information is maintained in cabinets, file rooms or computer files overseen by personnel trained in the maintenance of confidential information.

How long do we keep information about your child and when might we destroy it?

Public agencies must inform the parent when personally identifiable information is no longer needed to provide education services to the child. Personally identifiable information on a child with a disability may be retained permanently unless the parent requests that it be destroyed. If parents request that information be destroyed, the education agency may retain information such as your child's name, address, phone number and years in program. Parents should be aware that the records might be needed by the child or the parents for Social Security benefits or other purposes.

When do we give the information to others?

Information is not released to a third party without your written consent. We must keep a written record specifying with whom information about your child was shared (other than to your or to employees of the education agency or Regional Center).

What rights do parents have to view the information about their child?

Records about your child or your family must be made available for you to inspect no later than 5 working days after you have made the request (unless there is a court order or other document that specifically revokes your rights). Explanations and interpretations of the records must be provided if you request.

Where can I get more information about my rights?

You may always ask your service coordinator for more information. Additional information was provided to you on the Parent's Rights in Early Start form. Primary sources include: Title 34 Code of Federal Regulations Family Education Rights & Privacy Act of 1974, Title 20 of the United States Code, and California Early Start regulations.

If you have any questions about your child's records, please ask your service coordinator.

Please Keep For Your Records.



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900

28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450

43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Parents Rights and Responsibilities in the Early Start Program Initial and Annual Notice

Evaluation and Initial Assessment

Eligibility for the Early Start Program is determined by a review of pertinent records, information obtained from parental observation and report, and an evaluation administered by qualified personnel. If your child is determined to be eligible, you have the right to appropriate early intervention services. You have the right to provide information throughout the process and are encouraged to make decisions about your child's early intervention services. Procedural safeguards make certain that children and their parents or guardians are provided their rights under the law.

As a parent or guardian, you have the right to:

1. Be given the opportunity to begin the evaluation and initial assessment process.
2. Within 45 days after the referral of your child to a Regional Center or a local education agency, the evaluation and assessment activities must be completed and an Individual Family Service Plan (IFSP) meeting must take place to develop the IFSP.
3. Review the procedures and tests used in the assessment and evaluation.
4. Provide written permission before any evaluations or assessments are administered and refuse any evaluations, assessments and early intervention services.

5. Be fully informed of the results of evaluations and assessments.
6. Have access to records, including the right to examine and obtain copies of records relating to your child, and the right to request an amendment of records of any participating agency relation to your child.
7. Have an advocate assist you in dealing with the early intervention system, including Regional Center and local education agencies.
8. Obtain independent assessments and evaluations.
9. Have personally identifiable information maintained in a confidential manner.
10. Request a due process hearing to challenge the findings of any evaluations or assessments.
11. Attend a meeting to develop an IFSP within 45 days from referral.

Evaluation means the procedures used by appropriate, qualified personnel to determine your child's initial and continuing eligibility for early intervention services under the Early Start Program. These procedures require that:

1. Evaluation and assessment materials are administered in the native language of a child's parent/family or other mode of communication, unless it is clearly not feasible to do so.

2. Evaluation and assessment procedures and materials are selected and administered so as not to be discriminatory by race, sex, culture, or disabling condition.
3. Evaluation and assessment materials shall be appropriate for the specific purposes for which they are being used.
4. Evaluations and assessments are conducted by qualified personnel.
5. Evaluations or assessments administered to individuals with known visual, hearing, or communication impairments shall be selected to accurately reflect the individual's aptitude or achievement level, whichever factor is the subject of measurement.
6. Evaluation and assessment materials shall be designed to assess the specific areas of development and/or educational needs and not be designed to provide solely intelligence quotient measurement.
7. Assessments and evaluations are administered in the five developmental areas, including, where appropriate, health and development, vision, hearing, motor abilities, language functions, and social and emotional status.

Please Keep For Your Records.

Individualized Family Service Plan (IFSP)

If your child is determined to be eligible for early intervention, a meeting to develop your IFSP must take place within 45 days of your referral to a Regional Center or a local education agency. You have the following rights in developing and implementing the IFSP.

The right to:

1. Attend the meeting and participate in determining eligibility and developing the IFSP.
2. Request the attendance of other family members.
3. Request the attendance and participation of an advocate at the IFSP meeting.
4. Have the contents of the IFSP fully explained in your native language.
5. Give specific consent to each service listed on the IFSP. If you do not give consent to a service, it will not be provided. You may withdraw consent after initially receiving a service.
6. Provide concurrence to an assessment of your resources, priorities, and concerns regarding enhancing the development of your child.
7. Be notified in your native language and in advance, before an agency or service provider proposes or refuses to initiate or change the identification, evaluation, assessment, or educational placement of your child, or the provision of appropriate early intervention services to your child or your family.

Consent to the transmission of information about your child to the local education agency during transition to services under Part B of IDEA.

Administrative Proceedings

Parents may file written complaints regarding evaluation, assessment, placement, or service provision issues described above. Any parents involved in an administrative resolution of a complaint have the right to:

1. Be accompanied and advised by counsel and by individuals with special training with respect to early intervention services for children under age three.
2. Present evidence and confront, cross-examine, and compel the attendance of witnesses.
3. Prohibit the introduction of any evidence at the proceeding that has not been disclosed to you at least five days before the proceeding begins.
4. Obtain a written or electronic verbatim transcription of the proceeding.
5. Obtain written findings of facts and decisions within 30 days from the date the complaint is filed.
6. Have all personally identifiable information maintained in a confidential manner.
7. Require that the proceeding is carried out at a time and in a location which is reasonably convenient for you.
8. Bring civil action upon the other party in the complaint following completion of the proceedings.

Early Start Complaints

If a Regional Center, local education agency or private service provider violates a federal or state law or regulation governing the provision of early intervention services, you have the right to file a complaint directly to the Department of Developmental Services at the following address:

Department of Developmental Services

Office of Human Rights
Attention: Early Start Complaint Unit
1600 9th Street, Room 240,
MS2-15
Sacramento, California 95814

The complaint should be in writing and include the following information:

- Name, address, and phone number of the complaint
- A statement that a Regional Center, local education agency or service provider has violated a federal or state law governing the provision of early intervention services
- A statement of facts upon which the allegation is based
- The allegedly responsible party
- A description of the voluntary steps taken at a local level to resolve the complaint, if any.