

# Montana Milestones Part C of the IDEA Early Intervention Programs Referral Form for Regional Program providers\* Birth to Age 3

## CHILD/PARENT CONTACT INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Text Acceptable: ☐ Yes ☐ No Best Time to Contact: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Interpreter Needed: ☐ Yes ☐ No

## PARENT CONSENT FOR RELEASE OF INFORMATION

### *Consent for release of medical and educational information*

I, \_\_\_\_\_ (print name of parent or guardian), give permission for my child's health provider \_\_\_\_\_ (print provider's name), to share any and all pertinent information regarding my child, \_\_\_\_\_ (print child's name), with Montana Milestones Part C of the IDEA Early Intervention Program services. I also give permission for Montana Milestones to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Your consent is effective for a period of one year from the date of your signature on this release.*

Referring Person: _____	Referring Person Phone: _____
Referring Person E _____	
Referring Practice _____	Contact Person Phone: _____
Contact Person Em _____	Practice or Agency FAX: _____

## REASON FOR REFERRAL TO MT Milestones Part C of the IDEA Early Intervention SERVICES

**Provider: Complete all that applies. Please attach completed screening tool.**

Concerning screen: ☐ ASQ ☐ ASQ:SE ☐ PEDS ☐ M-CHAT ☐ Other

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

- |                                                                                              |                                          |                                          |
|----------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Communication                                                       | <input type="checkbox"/> Fine Motor      | <input type="checkbox"/> Personal Social |
| <input type="checkbox"/> Gross Motor                                                         | <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Other:          |
| <input type="checkbox"/> Clinician concerns (including vision and hearing) but not screened: |                                          |                                          |

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☐ Family is aware of reason for referral.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, **please complete the attached Physician or Psychologist Statement for Early Intervention Eligibility (on reverse) in addition to this referral form.** Only a physician or psychologist licensed by the State of Montana may sign the Statement.*

## PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Referring Provider Name: \_\_\_\_\_ Referral Contact Person: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

*If the child is eligible, medical provider will receive a copy of the Service Summary.*

## MT Milestones Part C of the IDEA Early Intervention EVALUATION RESULTS TO REFERRING PROVIDER

**MT Milestones Part C of the IDEA Early Intervention Services: please complete this portion, attach requested information, and return to the referral source above.**

☐ Family contacted on \_\_\_\_/\_\_\_\_/\_\_\_\_

The child was evaluated on \_\_\_\_ and was found to be:

- |                                                                       |                                                                               |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Eligible for services                        | <input type="checkbox"/> Not eligible for services at this time, referred to: |
| <input type="checkbox"/> Parent Declined Evaluation                   | <input type="checkbox"/> Parent Does Not Have Concerns                        |
| <input type="checkbox"/> Unable to contact parent                     | <input type="checkbox"/> Attempts: _____                                      |
| <input type="checkbox"/> Agency will close referral on ____/____/____ |                                                                               |

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**ESTABLISHED CONDITION STATEMENT FOR  
MONTANA MILESTONES PART C OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)  
EARLY INTERVENTION ELIGIBILITY  
(BIRTH TO AGE 3)**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

The State of Montana, through the Montana Department of Public Health and Human Services, provides Part C of the IDEA Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. MT DPHHS recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

MT DPHHS is requesting your assistance in determining eligibility for Montana Milestones Part C of the IDEA EI services for the child named above. Under Montana's law, a physician or psychologist licensed by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that has a high probability of resulting in developmental delay.

Please keep in mind that, while many children may benefit from Montana's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

**Diagnosed Condition (to be completed by the diagnosing physician or psychologist):**

\_\_\_\_\_  
Physician/Psychologist

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Montana Milestones Part C Early Intervention Program CONTACTS**

<b>Agency</b>	<b>Service Area</b>
<b>DEAP</b> 2200 Box Elder Miles City, MT 59301 (406) 234 6034 FAX (406) 234 7018	<b>Counties served:</b> Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, Wibaux
<b>Benchmark Human Services</b> 1601 2 <sup>nd</sup> Ave N Ste 349 Great Falls, MT 59401 (406) 403 0087 Toll Free: 866 235 4700 FAX (406) 403 0088	<b>Counties served:</b> Blaine, Cascade, Chouteau, Flathead, Glacier, Granite, Hill, Lake, Liberty, Lincoln, Mineral, Missoula, Pondera, Ravalli, Sanders, Teton
<b>Billings School District #2 Early Childhood Intervention</b> 2016 Grand Avenue Billings, MT 59102 (406) 281 5885 FAX (406) 245 1149	<b>Counties served:</b> Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone
<b>Family Outreach</b> 1212 Helena Avenue Helena, MT 59601 (406) 443 7370 FAX (406) 449 6062	<b>Counties served:</b> Beaverhead, Broadwater, Deer Lodge, Gallatin, Jefferson, Lewis and Clark, Madison, Meagher, Park, Powell, Silver Bow

Montana Milestones Part C of the IDEA Early Intervention Program contact information also available at this  
Montana Department of Public Health and Human Services web page:

<https://dphhs.mt.gov/dsd/developmentaldisabilities/montanamilestones>

or please call 1-406-444-5647

# Montana Milestones Part C of the IDEA Early Intervention Programs Referral Form for Regional Program providers\* Birth to Age 3

## Consent for Use or Disclosure of Health Information Between Healthcare Providers and Montana Milestones Part C of The Idea Early Intervention Programs

### ***Information for Parents***

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to Montana Milestones Part C Early Intervention programs. ***This consent form also authorizes the disclosure of developmental and educational information from the Montana Milestones Part C Early Intervention programs to your child's health care provider.***

### ***Why is this consent form important?***

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Montana Milestones Part C Early Intervention program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and regional Montana Milestones Part C Early Intervention programs, so these agencies can work together to help your child.

### ***Why am I asked to sign a consent on this form?***

The consent allows your child's health care provider to share information about your child with Montana Milestones Part C Early Intervention programs and allows Montana Milestones Part C Early Intervention programs to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and Montana Milestones Part C Early Intervention programs to communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

### ***How will this consent be used?***

This consent form will follow your child as he/she is screened and/or evaluated at one of the regional Montana Milestones Part C Early Intervention programs. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with Montana Milestones Part C Early Intervention or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

### ***How long is the consent good for?***

This consent is effective for a period of one year from the date of your signature on the release.

### ***What are my rights?***

You have the following rights with respect to this consent:

- You may revoke this consent at any time.
- You have the right to receive a copy of the Authorization.