FIRST CONNECTIONS
PROGRAM PARTICIPATION AUTHORIZATION

CHILD'S NAME_____ **CHILD'S ID NUMBER**_____

PARENT/GUARDIAN _____ **SERVICE COORD.**_____

CONSENT TO PROVIDE SERVICES:

I understand that I have the right to notice and consent to any action taken concerning my child in my native language. I am authorizing Developmental Disabilities Services and the First Connections Program to assist my child and family to access and pursue services to assist my child in developing to his/her fullest potential. I also understand that the Individual Family Service Plan (IFSP) Team have determined the following early intervention services are necessary to complete the IFSP, and I hereby authorize their provision.

X	SERVICE	X	SERVICE	X	SERVICE	X	SERVICE
	Developmental Therapy		Family Therapy		Speech Therapy		Occupational Therapy
	Physical Therapy		Audiological Services		Vision Services		Health Services
	Social Work Services		Nutrition Services		Nursing Services		Medical Services
	Assistive Technology		Service Coordination		Transportation		Psychological Services

Parent/Guardian Initial **___Yes** **___No** _____**Date**

CONSENT TO OBTAIN/RELEASE INFORMATION:

I understand that I have the right to notice and consent in my native language, before any personally identifiable information about my child is released or obtained. I understand that I can revoke this authorization at any time. I also understand that I may examine any and all records pertaining to my child at any time. I am authorizing Developmental Disabilities Services and the First Connections Program to __X__obtain from / __X__release information to:

Organization/Individual_____ _____

Address _____ _____

_____ _____

Information to be Released **Early Intervention records**_____

Parent/Guardian Initial **___Yes** **___No** _____**Date**

FAMILY CHOICE OF PROVIDERS:

I have been provided a list of providers available to deliver the above identified First Connections/Early Intervention and other services and have chosen the following providers:

X	Service	Provider	X	Service	Provider
	Developmental Therapy			Nursing Services	
	Speech Therapy			Social Work Services	
	Physical Therapy			Vision Services	
	Occupational Therapy			Medical Services	
	Audiological Services			Nutrition Services	
	Service Coordination			Health Services	
	Assistive Tehcnology			Transportation Services	
	Family Therapy			Psychological Services	

___Parent/Guardian Initial _____**Date**

_____ _____ **(Form # FC-F)** **(electronic signature version 3/2020)**

Parent/Guardian Signature **Date**

(0 to 3 form)