Washington State Department of Social & Health Services

WORKFIRST - PUBLIC HEALTH
CHILDREN WITH SPECIAL NEEDS INITIATIVE

Special Needs Evaluation and Engagement Recommendations

PARENT/GUARDIAN'S NAME		JAS IDENTIFICATION NUMBER
CHILD'S NAME		CHILD'S BIRTHDATE
EVALUATION COMPLETED? ☐ Yes ☐ No	IF NO, CHECK APPROPRIATE BOX ☐ Client refused ☐ Client not home ☐ Did not respond to mail ☐ Did not respond to phone call	DATE OF EVALUATION
PRIMARY HEALTH CARE PROVIDER NAME	ADDRESS	PHONE NUMBER (WITH AREA CODE) ( )

1. Child's Information

List the child's diagnosis and medical condition:

Describe the care requirements of the child that affects the parent's ability to participate in normal daily work related activities. Include the total hours / day and days / weeks.

Describe how many hours the child attends school each week and whether an IEP / 504 Behavioral Plan is in place or is needed.

List specific services for the child that would provide needed supports to help the parent participate in work or work-like activities:

2. Summary and Recommendations

Given the child's condition, check the appropriate box:

☐ The parent can participate 0 – 10 hours per week.
☐ The parent can participate 11 – 20 hours per week.
☐ The parent can participate 21 – 30 hours per week.
☐ The parent can participate more than 30 hours per week.
☐ Please contact me for further information.

How long do you expect the parent will need to provide this level of care: _____

PUBLIC HEALTH NURSES'S NAME (PRINT)			COUNTY
PUBLIC HEALTH NURSE'S SIGNATURE	DATE	PHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)