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) |