Rhode Island Early Intervention Program Services Rendered Form Exit/Discharge

Last Name: **First Name:** **MI** **ID:** **DOB:** / /

Service Date: / / **Service Coordinator:** **Insurance Change**: ☐ Yes ☐ No

Visit Participants:

Service Location: ☐ H (Home) ☐ V (Virtual) ☐ C (Community) ☐ CB (Center Based) ☐ EIGC (EI Group in the Community) ☐ N/A (Not Applicable)

Exit/Discharge Date: / / **Complete Exit or Discharge section below depending on the child's IFSP status**

EXIT (child with no IFSP)

☐ Attempts to contact unsuccessful
☐ Child did not qualify for EI

☐ Family switched to another EI site
Provider:
☐ Moved out of state

☐ Withdrawal by parent/guardian; i.e. parent declines services before initial IFSP meeting
☐ Deceased

DISCHARGE (child with IFSP)

☐ Program Completion
- IFSP team, including the parent, has determined all identified goals were reached; parent declines multidisciplinary evaluation; decides to end EI services

OR
- Child no longer meets eligibility criteria for EI as determined by multidisciplinary evaluation

☐ Attempts to contact unsuccessful

☐ Family switched to another EI program.
Program name:

☐ Withdrawal by parent/guardian while child is still eligible; i.e. parent declined services
☐ Moved out of state
☐ Deceased

SPECIAL EDUCATION SERVICES

☐ Part B eligible
☐ Not eligible for Part B with referrals to other programs
☐ Not eligible for Part B with no referrals to other programs
☐ Part B eligibility not determined at time of discharge

Name of town responsible for special education services:

IEP Date: / / or Anticipated IEP Date: / /
Reason anticipated: ____

REFERRAL INFORMATION

Check all categories for referrals made in which EI assisted the family by providing the new program with necessary information

☐ Cedar Family Centers
☐ Community Childcare/Preschool
☐ Child Outreach
☐ Community Mental Health Program
☐ Community Resources

☐ Dept. of Health Family Visiting Program
☐ Early Head Start/ Head Start
☐ Family Support
☐ Kids Connect
☐ Providence Talks

☐ RI Community Action Agencies
☐ SNAP (Supplemental Nutrition Assist Prog.)
☐ WIC (Supplemental Nutrition Program)
☐ Other

NOTES

Note any specific details re: resources/information provided to family (e.g. agency name, contact, phone #, description of services. etc.)

FINALIZE CHILD OUTCOMES MEASUREMENT PROCESS

Has the child's present levels of development and functioning been discussed with the family, and the COS C been completed?

☐ Yes ☐ No

Procedural Safeguards
I have received a copy of my procedural safeguards. These rights have been explained to me and I understand them.

Parent/Guardian Signature Date

Provider/Signature	Date	Service Code:	Minutes:
1.	/ /		
2.	/ /		
3.	/ /		
4.	/ /		