Early Support for Infants and Toddlers Program/Children with Special Healthcare Needs

Child Health Intake Form/ ESIT Referral

Early Support for Infants and Toddlers (ESIT) is part of the Children with Special Health Care Needs Program at the Spokane Regional Health District (SRHD). This program is funded, in part, through the Individuals with Disabilities Education Act (IDEA), Part C. The program offers additional resources to families of infants and toddlers under the age of three who are receiving early intervention services such as physical, occupational, speech, or feeding therapy. Included are services and therapies in the home. SRHD ESIT also provides funding support for early intervention services and/or equipment if no other funding source is available.

Each family is assigned to one of the five contracted therapy centers, as per parent choice (please circle if family has a preference):

- Center for Pediatric Therapy
- Children First Therapy
- Joya Child & Family Development
- Stepping Stones Pediatric Therapy
- Youthful Horizons

A Family Resource Coordinator (FRC) is assigned to each family.

Please complete the form and fax to ESIT: 509.324.1699
For questions or assistance call: 509.324.1651

Referred/Completed by: ________________________________Phone:________________ Date___________________

Child Name:__________________________________ Date of Birth:______________ Male Female

Premature? Yes No If yes, gestational age: ________________ Eat/Sleep/Console? Yes No

Diagnosis/Area of Concern:____

Name of Parents: ____ Parents Foster Parents Relative Placement

Address:________________________________ City:___________ State: WA Zip Code:___________ County: Spokane

Home Phone:_______________ Cell Phone:________________ Email:____

Child's Physician: ____ Phone:___________________________

CPS Involved? Yes No Case Manager/Phone:____

School District:_______________ Family Size:______ Needs Interpreter? Yes No Language:________________

Race: _______________ Insurance (check all that apply):

Ethnicity:

Hispanic or Latino/a

Non-Hispanic or Latino/a

Apple Health Insurance Name:_______________________________________
Provider One # (ends in WA):_____________________________
With Apple Health do you pay? Yes NO

Private Insurance Name:_______________________________________

Secondary Insurance Name:_______________________________________

For SRHD ESIT USE

Name of person completing this form:____ Date:____________________________

FRC Assignment________________________________ Provider____