Request for Determination of Continuing Area Agency Eligibility Under He M 503

Today's Date	
Name of Child	
Date of Birth	
DUCK	
Diagnosis	
Parent/Guardian(s) Name	
Address	
Phone	
ESS Provider Agency	
Person Filling Out This Form	Name: Phone:

I choose not to request determination of continuing eligibility for services through the Area Agency at this time.

Signature of Parent/Guardian: ________________________________ Date: ______________

I request that the Area Agency review any records and assessments needed to determine continuing eligibility for Area Agency services under RSA 171-A and He-M 503.

Signature of Parent/Guardian: ________________________________ Date: _____________

This family already receives

Family Support Services	Yes _____	No _____
Respite Care	Yes _____	No _____
In Home Supports Funding	Yes _____	No _____
Partners in Health Services	Yes _____	No _____

This family requests information about Family Support services. Yes _____ No _____

I request a referral for determination of eligibility for Partners in Health services.

Signature of Parent/Guardian: ________________________________ Date: _____________

Developmental Skill Area	Is there delay? YES	NO	Comments	Age Equivalent
Sensory Organization				
Play/Cognitive				
Communication				
Expressive				
Receptive				
Gross Motor/Mobility				
Fine Motor				
Visual motor				
Perceptual				
Social/Emotional				
Self-Care/Feeding				

CURRENT SERVICES	FREQUENCY ESS and other providers	COMMENTS (type, by whom)
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Behavioral Therapy		
Educator Services		
Autism Supports (Specialist/paraprofessional)		

SPECIAL CARE	SPECIAL REQUIREMENTS	COMMENTS
Vision		
Hearing		
Mobility		
Other		

Report of Service Coordinator– List any concerns not addressed above :