



Disabilities Parent Questionnaire - Early Head Start

Questionnaire for the parent/guardian of a child who is currently receiving services or in the process of being evaluated by an early intervention agency and was not referred by our program.

Child's Name _____ Date _____

Area of Disability _____

Parent's Name _____ Phone Number _____

Staff's Name _____

_____ I need more information about my child's special need

My child's special need is _____

Specific information needed: _____

_____ I need more information about the early intervention process

_____ Evaluation

_____ IFSP (Individual Family Service Plan)

_____ Other _____

I need more information about:

_____ Supplemental Security Income

_____ Division of Developmental Disabilities

_____ Health Information

Specific need: _____

_____ Support Groups for Parents

For children receiving special services:

_____ I know the name of my child's special education teacher and/or therapist

_____ I know how to get in touch with my child's special education teacher and/or therapists

Other information needed: _____