Request for Inclusion Services

Upon completion email to: ccs.support@wfscapitalarea.com

Parent: _____ Child: _____ DOB:_____

Parent's Phone Number: _____ TWIST ID: _____

Center/Provider's Name: _____ Center/Provider's Number: _____

Center Address: _____ Center License Number: _____

Who is requesting inclusion services? (Check all that apply)

☐ Parent / Guardian ☐ Provider (Teacher, Director, or Child Care Staff)

Please explain any developmental concerns (speech, behavior, motor, etc.): _____

_____

_____

_____

By signing below, you are consenting to one or more of the following screenings an ASQ-3, ASQ:SE-2, or other assessment tool, and an observation to be conducted at the childcare center listed above. Following the screenings / assessment and the observation a staff member from Workforce Solutions will contact you with recommendations and resources.

☐ **I agree that all developmental screenings / assessments reports may be released to my child's school/ childcare center.**

_____

Parent /Guardian Signature **Name** **Date**

For Workforce Solution use only:

Date Requested: _____

Contact Person: _____ Phone Number: _____

Accomplishment: _____

Inclusion Specialist: _____ Observation Date: _____

Individualized Services: _____ Appointment (if applicable): _____

Notes: _____