SHASTA HEAD START CHILD DEVELOPMENT, INC.

REFERRAL RESPONSE FORM

Date: _____

To: _____

RE: _____

We have received the referral indicated above and have begun the referral response process. Below you will see an action plan for our department and an action plan for you.

If you have any questions or concerns, please call or email our department.

DISABILITIES AND MENTAL HEALTH ACTION PLAN

FAMILY WORKER/HOME VISITOR ACTION PLAN

Immediately notify Dis./M.H. Dept. if child attends SCOE collab. class in afternoon

Have staff work on the ASQ-3 activities in areas of concern with the parent(s) in the meantime.

_____ _____

***Please sign, respond to any questions, and scan back to the Disabilities Department.**