



**State of Florida  
Department of Children and Families**

**Rick Scott**  
Governor

**David E. Wilkins**  
Secretary

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**DATE:** March 11, 2011

**TO:** Regional Directors

**THROUGH:** Pete Digre, <sup>*Pete Digre, for Peter Deane*</sup> Assistant Secretary for Operations

**FROM:** Jamie Self, <sup>*J Self*</sup> Ed.D., Director of Family Safety

**SUBJECT:** Child Abuse Prevention and Treatment Act - Early Steps Referrals  
**ACTION REQUIRED:** Notification to Lead Agencies and Sheriff Grantees  
**DUE DATE:** Effective Upon Receipt

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**PURPOSE:** This memorandum provides information on the revisions to the Early Steps Referral form.

**BACKGROUND:** The Child Abuse Prevention and Treatment Act (CAPTA) requires states to have in place referral procedures to early intervention services for children under the age of three who are involved in substantiated cases of child abuse or neglect to (Part C of the IDEA [42 U.S.C. 5106a, Sec. 106 (b)(2)(A)(xxi)]). Florida has defined "substantiated" as any case with verified findings of child abuse or neglect.

The Infants and Toddlers with Disabilities Program (Part C of IDEA) is a federal grant program that assists states in fulfilling the federal requirement to implement a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, from birth up to 36 months of age, and their families. Florida's Early Steps is the lead agency for this federal program.

Both the Department (DCF) and the Department of Health entered into an Interagency Agreement in 2008 as part of the state's plan to meet federal provisions. Section VI of the Interagency Agreement (IA) defines agency responsibility (See attached IA). Please note Section VI (2) requires the reason for referral must be included on the referral form.

In order to adhere to Florida's CAPTA plan for Part C, the Early Steps referral form (CF FSP- 5322) has been revised. The form now captures demographic information on the parent/caregiver and guides staff in identifying the conditions or specific area of concern that may make an age appropriate infant or toddler involved in a verified finding of abuse or neglect eligible for Early Steps. The form (CF FSP- 5322) is available on the Department's Intranet through the *DCF Forms* link or at:  
<http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx>

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Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

**ACTION REQUIRED:** Please notify the CBC Lead Agencies of this revised form for referral to Early Steps for early intervention services and implement the use of the revised form upon receipt.

**CONTACT INFORMATION:** If you have any questions regarding this information, please contact Johana Hatcher at (850) 488-1929 or [johana\\_hatcher@dcf.state.fl.us](mailto:johana_hatcher@dcf.state.fl.us).

Attachments

cc: DCF Contract Managers



## EARLY STEPS REFERRAL CHECKLIST

**Instructions:** If a child has any condition or concern that has a *high probability of being associated with a developmental delay or poor behavioral outcome* the child should be referred for early intervention services, Early Steps. This checklist identifies condition(s) or specific area of concern(s) that may make an **infant or toddler, birth to 36 months of age**, eligible for early intervention services. **Please check all applicable items.**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Parent/Caregiver Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

<b>CERTIFIED CONDITION</b>	<input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment/blind <input type="checkbox"/> Chromosome anomaly ( <i>such as Down's Syndrome</i> ) <input type="checkbox"/> Neurological condition ( <i>such as Cerebral Palsy</i> ) <input type="checkbox"/> Seizure Disorder ( <i>such as epilepsy</i> ) <input type="checkbox"/> Physical abnormality/abnormal movement <input type="checkbox"/> _____
<b>DEVELOPMENTAL DELAYS</b>	<input type="checkbox"/> 3 months and child does not watch moving objects or respond to sounds <input type="checkbox"/> 6 months and unable to roll over <input type="checkbox"/> 9 months and unable to sit alone <input type="checkbox"/> 12 months and unable to crawl ( <i>or crawls with great difficulty</i> ) <input type="checkbox"/> 15 months unable to stand alone <input type="checkbox"/> 15 months and unable to hold a cup <input type="checkbox"/> 18 months and has no speech or only babbles <input type="checkbox"/> 18 months and unable to walk <input type="checkbox"/> 24 months and unable to use objects like crayons or spoons <input type="checkbox"/> 24 months and does not engage in play or social interaction <input type="checkbox"/> _____
<b>OTHER CONCERNS</b>	<input type="checkbox"/> Feeding/Eating difficulty <input type="checkbox"/> Shaken baby/head injury <input type="checkbox"/> Chronic illness <input type="checkbox"/> Child in hospital or recent hospitalization <input type="checkbox"/> Child extremely underweight or appears malnourished <input type="checkbox"/> Lack of eye contact or lack of interest in interaction with parent/caregiver <input type="checkbox"/> Substance abuse exposure or withdrawal symptoms (prenatal drug exposure or Fetal Alcohol Syndrome) <input type="checkbox"/> _____