North Los Angeles County Regional Center

9200 Oakdale Avenue, Suite 100, Chatsworth, CA 91311 - (818) 778-1900
25360 Magic Mountain Parkway, Suite 150, Santa Clarita, CA 91355 - (661) 775-8450
43210 Gingham Avenue, Lancaster, CA 93535 - (661) 945-6761

Early Start Application

(Infants and Toddlers under 3 years of age)

Child's Information: Please provide complete information regarding the child being referred.

First Name | **Middle Name** | **Last Name**

Birth Date | **Age** (in months) | **Birth Place** | **Gender** ☐Male ☐Female

Preferred Language for Communication with Regional Center | **Other Languages Spoken**

Ethnicity | **Social Security Number**

If the Child's name has been changed, please list previous name below.

Previous First Name | **Previous Middle Name** | **Previous Last Name**

Who does the child live with? ○ Parents ○ Mother Only ○ Father Only ○ Foster Parents ○ Facility

Street

City | **State** | **Zip**

Who is the primary legally responsible party that can be contacted regarding the Child's application?

First Name | **Last Name** | **Relationship**

Primary Phone Number | **Alternate Phone Number** | **E-mail Address**

Please provide information regarding the individual, agency, or office that made referral.

Name of Agency / Contact Person | **Primary Phone Number** | **Fax / E-mail**

Has the child received assessment or services from another Regional Center? ☐Yes ☐No

If "Yes," please name the Regional Center in the box.

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Father's Information

Does the Father live with the Child? If, "Yes" please check here. ☐

If the Father's information is unknown please check here. ☐

First Name	Middle Name	Last Name

Birth Date	Birth Place	Language

Street

City	State	Zip

Phone Number	Social Security Number

Employer's Name	Job Title

Disabled ◯ Yes ◯ No **Deceased** ◯ Yes ◯ No

Marital Status ◯ Married ◯ Divorced ◯ Separated ◯ Single ◯ Widower

Age of Father at Child's birth? _____ **Number of Children?** _____

Mother's Information

Does the Mother live with the Applicant? If, "Yes" please check here. ☐

If the Mother's information is unknown please check here. ☐

First Name	Middle Name	Last Name

Birth Date	Birth Place	Language

Street

City	State	Zip

Phone Number	Social Security Number

Employer's Name	Job Title

Disabled ◯ Yes ◯ No **Deceased** ◯ Yes ◯ No

Marital Status ◯ Married ◯ Divorced ◯ Separated ◯ Single ◯ Widower

Age of Mother at Child's birth? _____ **Number of Children?** _____

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Medical History (Medical record release is required to confirm information.)

Was the child in a neonatal intensive care unit or were there birth complications? ☐ Yes ☐ No

Please describe birth weight, level of prematurity, and any complications in the box below.

Does the child have any medical diagnoses or conditions? ☐ Yes ☐ No

Does the child have a visual impairment? ☐ Yes ☐ No

Please describe in box below.

Please describe your primary concerns with the Child's development.

Language Development

1. How many words does the child have? _____
2. Does the child combine words? ☐ Yes ☐ No
3. Has the child lost speech? ☐ Yes ☐ No
4. Does the child understand and follow commands? ☐ Yes ☐ No
5. Does the child respond to his/her name? ☐ Yes ☐ No
6. Has the child's hearing been tested? ☐ Yes ☐ No

In the box below please describe any concerns about the Child's language development.
Also indicate results of hearing test, if applicable.

Physical Development

List age in months the child could do the following:

Support Head		Roll Over		Sit Without Support	
Pull Self To Stand		Walk By Holding Furniture		Walk With Hand Held	
Walk Without Support					

Please describe any concerns about the child's physical development in the box below.

Social - Behavioral

Please describe any concerns about the child's social interaction and / or behavior in the box below.

Please complete entire form and fax to Intake Department (818) 756-6170
or submit electronically to earlystartintake@nlacrc.org

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Clinician Contact Information For Medical Record Request

Please indicate the name and contact information for the child's birth hospital or NICU, current physician and/ or other medical specialist and then please sign the corresponding consents to obtain current records from these providers on pages 6, 7 and 8.

A. Birth Hospital / Neonatal Intensive Care Unit (NICU)

Name

Street

City **State** **Zip**

Phone Number

B. Current Physician

Name

Street

City **State** **Zip**

Phone Number **Specialty**

C. Other Current Physician or Medical Specialist (for example, Neurologist, Geneticist, Orthopedic Specialist)

Name

Street

City **State** **Zip**

Phone Number **Specialty**

IMPORTANT: Please submit a copy of the applicant's insurance card with your application. This is required by California law.

Insurance Information

Insurance Company Name **Insurance Company Phone Number** **Medi-Cal** ☐

Name of Policy Holder **Insurance Policy Number**

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CONSENT FOR EVALUATION AND RELEASE OF INFORMATION

Consent for Evaluation and Release of Information: Your written consent is needed before an evaluation can be conducted. Additionally, your written consent is needed to allow your personal information to be released to a regional center vendored service provider for the purpose of coordinating the evaluation. The evaluation will help you and the regional center learn about your child and may include talking with you about your child's development, an observation of your child in the home or other settings, and a review of medical and/or other records. This information will assist the NLACRC in determining your child's eligibility for California's Early Start Program and help us identify the type of early intervention services needed.

For Your Information:

- Your consent for evaluation is entirely **voluntary** and **may be withdrawn at any time**.
- The evaluation is required to determine eligibility; without an evaluation services may not be provided.
- The evaluation will be completed in the primary language of your child and family and in a timely manner.
- The evaluation will help you to identify your concerns for your child and family.
- The evaluation will provide information about your child's development.
- You may request information regarding the evaluation as well as a copy of the results.
- Your child's and family information is strictly confidential and will only be released with your written consent.
- No services shall start, change or terminate without written notification or the written consent of the family.
- You have the right to review and inspect your child's records.
- You have a right to receive further written information about your rights.

Your child will be assessed in the following areas:

- cognitive development
- speech & language (communication) development
- social or emotional development
- physical/motor development
- adaptive development

By signing this form, I agree for NLACRC to:

Complete a developmental evaluation in all five (5) developmental domains to help determine if my child is eligible or continues to be eligible for Early Intervention Services. I understand that my consent is voluntary and that I may refuse evaluation services at any time.

Release personally identifiable information to a regional center vendored service provider for the purpose of referral for evaluation. I understand that this information will include but is not limited to the names of the parents and child, child's date of birth, home address, and telephone number(s).

Release personal identifiable information to an agency that my child may have a "potentially eligible" condition and provide further assistance, and generic resources. I understand that my child may be referred to such agencies as the Local Education Agency (LEA), Family Resource Center (FRC), California Children Services (CCS), and/or Early Head Start, etc. I understand that NLACRC will not release my information without first contacting us to confirm the name of agency. I also understand that I have the right to revoke the release of my information at any time.

Name of Child _____ **Date of Birth** _____

Parent Signature _____ **Date** _____

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AUTHORIZATION FOR RELEASE OF DEVELOPMENTAL AND EDUCATIONAL INFORMATION

I hereby authorize the **NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)** and/or its designated employees to release protected health information, including medical , developmental and/or educational information as indicated below to assist with transition planning with the local education agency.

Please release medical records and/or other information regarding:

Name: _____ Birth Date: _____

UCI#: _____

Release records to: _____ Attention: _____

_____

_____

REVOCATION
This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

REDISCLOSURE
NLACRC and many other organizations and individuals are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may not longer be protected by state or federal confidentiality laws.

DURATION
This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date is entered.

INFORMATION DISCLOSED MAY INCLUDE:

1. Personal Identifiable Information (child's name, DOB, parent(s) name, family address, and phone number)
2. Developmental Evaluations and Assessments
3. IFSP (Individual Family Service Plan)
4. Psychological Evaluation
5. Other related education information:

I/We authorize NLACRC to transmit information about my/our child to the Local Education Agency including evaluation and assessment information and copies of IFSP(s) that have been implemented to help the LEA identify needed assessments to determine special education eligibility under IDEA Part B by age 3.

I understand that this authorization is voluntary and can be revoked at any time. I understand that I have the right to omit certain records from being disclosed to the LEA.

I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

_____ _____
Signature of Consumer or Consumer's Legal Representative Date

_____ _____
Printed Name Relationship, if signed by someone other than consumer

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL, EDUCATIONAL AND/OR OTHER PROTECTED HEALTH INFORMATION

To: _____ Attention: _____

_____

_____

I hereby authorize the above named medical practitioner, hospital, clinic, mental health facility, school and/or its designated employees to release the protected health information and/ or educational records as indicated below

Please release medical records and/or other information regarding:

Name: _____ Birth Date: _____

Release medical information to: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)

DURATION

This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date is entered.

REVOCATION

This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

REDISCLOSURE

NLACRC may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

SPECIFY RECORDS

Check the box and initial the type of information to disclose:

☐ **Medical Information:** birth records, office visits, physical examinations, developmental assessments, hospital admission and discharge summaries.

☐ **Educational Records**

☐ **Psychiatric/Psychological Information:** mental health evaluation and treatment records, psychological/ psychiatric diagnostic assessments including testing score sheets.

Signature _____

☐ **HIV, AIDS**

Signature _____

☐ **Other** (specify) _____

I request that the health information released pursuant to this authorization be used for the following purposes only: These records will be used by the NLACRC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

_____ _____
Signature of Consumer or Consumer's Legal Representative Date

_____ _____
Printed Name Relationship, if signed by someone other than consumer

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL, EDUCATIONAL AND/OR OTHER PROTECTED HEALTH INFORMATION

To: _____ Attention: _____

_____

_____

I hereby authorize the above named medical practitioner, hospital, clinic, mental health facility, school and/or its designated employees to release the protected health information and/ or educational records as indicated below

Please release medical records and/or other information regarding:

Name: _____ Birth Date: _____

Release medical information to: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)

DURATION

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REVOCATION

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Signature _____

☐ **HIV, AIDS**

Signature _____

☐ **Other** (specify) _____

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Signature of Consumer or Consumer's Legal Representative Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The North Los Angeles County Regional Center (NLACRC) is mandated by law to maintain the privacy of your Protected Health Information (PHI). PHI is information that identifies you in any form (electronic, written, oral, etc.) collected, created, maintained, or received by NLACRC relating to your past, present or future physical/ mental health or condition. We are required by law to provide you, a NLACRC consumer, with this "Notice of Privacy Practices" explaining our legal duties and privacy practices concerning your PHI. We are also required to abide by the terms of the current version of this Notice. In this Notice, the terms "NLACRC", "we", "us", and "our" refer to the North Los Angeles County Regional Center.

WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING SITUATIONS:

Treatment: We may use and disclose your PHI for the provision, coordination and/or management of health care and related services. For example, we may disclose your PHI to case managers, doctors, health care providers, vendors, business associates, caregivers, family and other persons who are involved in taking care of you, both within and outside of NLACRC.
Health Care Operations: We may use and disclose your PHI for our Operations. For example, activities involving, but not limited to, case management, quality assessment and improvement, risk mitigation, oversight by state and federal agencies, audit, training, and advocacy. This may include sharing your information with the California Department of Developmental Services (DDS), and other California regional centers when required.
Payment: We may use your PHI to, for example, determine our responsibility to pay for, or to permit us to bill and collect payment for the treatment and health-related services that you receive.
Appointment Reminders and Notification: We may contact you about appointments or provide you with information that may be of your interest.
Public Health Activities: We may share your PHI for Public Health Activities, for example, when related to prevention of disease, injury or disability; for tracking and monitoring of certain medical products.
Judicial Proceedings: We may use or disclose your PHI for Judicial Proceedings, for example, as part of an administrative hearing, in response to an order of a court, or a subpoena.
Law Enforcement: We may share your PHI with Law Enforcement Agencies, for example, to respond to a search warrant or to report a crime.
Research: We may use or share your PHI for research approved by NLACRC and an Institutional Review Board, a committee that is responsible, under law, for reviewing and approving research to protect the safety of the participants and the confidentiality of PHI. Participation in any such research may also require your specific authorization.
Serious Threat to Health or Safety or Disaster Relief: We may use or share your PHI to prevent serious/ imminent threat to your or another person's health and safety.
National Security: We may share PHI with authorized federal officials for intelligence, and other national security activities authorized by Law.
Coroners, Medical Examiners, Funeral Directors and Organ Donation: We may share your PHI with these agencies, as applicable by law, to allow these individuals to perform their official duties; for example, to identify a deceased person.
Correctional Institutions: If you are under law enforcement custody, we may share your PHI with correctional institutions or law enforcement, as needed, for your health care.
As Mandated by Law: We will share your PHI when otherwise required by law.

OTHER USES OF PROTECTED HEALTH INFORMATION
Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. The permission you provide us to use or disclose your PHI may be revoked in writing at any time. If you revoke your permission, this will stop any further use or disclosure of your PHI for the purposes covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. There are stricter requirements for the use and disclosure of certain types of PHI, for example, records about HIV/AIDS, mental health, drug and alcohol treatment. This type of information can only be released in accordance with those stricter laws.

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YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI) INCLUDE:

Right to Inspect and Copy your Records You have the right to request in writing to inspect and copy your PHI in designated record sets. If we deny a request, we will do so in writing giving our reasons and you have the right to have that decision reviewed.

Right to Request Amendments to your Records If you feel that your PHI is incorrect or incomplete, you have the right to ask in writing that we amend it, stating why we should make the correction or addition. If we deny your request, we will do so in writing giving our reasons, and you may file a written statement of disagreement.

Right to Request Restrictions You have the right to request in writing a restriction or limitation of our use or disclosure of your PHI. You may request that your PHI not be shared with others, like a family member or friend. However, by law, we do not have to agree to your request.

Right to Request Confidential Communications You have the right to request in writing that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. When we can reasonably or lawfully agree to your request, we will.

Right to an Accounting of Disclosures You have the right to request in writing an accounting of our disclosures of your PHI for up to 6 years before your request, but not for disclosures made before April 14, 2003. An accounting does not include disclosures to carry out Treatment, Health Care Operations, Payment, General Notification, Law Enforcement, National Security, and to Correctional Institutions as well as otherwise Mandated by Law. Additionally, an accounting does not include disclosures for which NLACRC had a signed authorization, disclosures to you, your care giver, or persons acting on your behalf.

Right to a Paper Copy of this Notice You have the right to receive a paper copy of this Notice upon request at any time. Copies can be downloaded from **www.nlacrc.org**, provided by reception at any of our offices, or through your case manager.

CHANGES TO THIS NOTICE We reserve the right to change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. A copy of the current Notice will be posted at all NLACRC offices in a clear and prominent location. If we change our Notice, you may obtain a copy of the revised Notice from the NLACRC web site, reception, or your case manager.

QUESTIONS/COMPLAINTS If you have questions regarding this Notice or our privacy practices, or if you are writing about your PHI, including requests for restrictions on its use or disclosure, or to make a complaint about our privacy practices, please write to NLACRC, Attn: HIPAA Privacy Officer, 15400 Sherman Way, Suite 170, Van Nuys CA 91406, or call 818-778-1900. If you believe your privacy rights have been violated, you may also notify the Secretary of the Department of Health and Human Services (HHS). You will not be penalized for filing a complaint.

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Protecting your Child's Confidentiality: What You Need To Know Initial And Annual Notice

Before a child is evaluated for services in the Early Start program and at least once every year thereafter, we are required to tell you in writing what information we collect about your family and your child and what we do to ensure that this information is kept confidential. The following information is very important to your family.

What information do we keep on file that could be used to identify your child?
We keep on file "personally identifiable" information such as a child's full name, parent's names, child's address, Social Security number or other personal identifiers, and information related to the child's diagnosis, gender, ethnicity, etc.

Where do we obtain information about your child?
Information is gathered from persons or agencies that have referred your child for Early Start services and from you, the parent. With your written consent, information also is gathered from other persons/agencies who know your child. These persons may include doctors, teachers, social workers and specialists from hospitals, Regional Centers, schools, etc.

How do we use the information we have about your child?
We use the information to determine if your child *is* eligible for Early Start services. If your child *is* eligible, we use the information to help plan services. If your child *is not* eligible now, the information will be stored for possible future need for re-referral for services before your child is three.

What information do we use to assess your child and to develop the Individual Family Services Plan (IFSP)?
A team of professionals from several disciplines and you, the parent, use information from many resources to assess your child and to develop the IFSP. Medical records and health status reports, information obtained from developmental observations of your child, parent report and interviews, standardized tests or instruments may be used.

Where do we keep information about your child?
The information about your child will be kept *in* the work station of your child's service coordinator or a centralized file room. All personally identifiable information is maintained in cabinets, file rooms or computer files overseen by personnel trained in the maintenance of confidential information.

How long do we keep information about your child and when might we destroy it?
Public agencies must inform the parent when personally identifiable information is no longer needed to provide education services to the child. Personally identifiable information on a child with a disability may be retained permanently unless the parent requests that it be destroyed. If parents request that information be destroyed, the education agency may retain information such as your child's name, address, phone number and years in program. Parents should be aware that the records might be needed by the child or the parents for Social Security benefits or other purposes.

When do we give the information to others?
Information is not released to a third party without your written consent. We must keep a written record specifying with whom information about your child was shared (other than to you or to employees of the education agency or Regional Center).

What rights do parents have to view the information about their child?
Records about your child or your family must be made available for you to inspect no later than 5 working days after you have made the request (unless there is a court order or other document that specifically revokes your rights). Explanations and interpretations of the records must be provided if you request them.

Where can I get more information about my rights?
You may always ask your service coordinator for more information. Additional information was provided to you on the Parents' Rights in Early Start form. Primary sources include: Title 34 Code of Federal Regulations Family Education Rights & Privacy Act of 1974, Title 20 of the United Stated Code, and California Early Start regulations.

If you have any questions about your child's records, please ask your service coordinator.

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Parents' Rights and Responsibilities in the Early Start Program
Initial and Annual Notice

Evaluation and Initial Assessment

Eligibility for the Early Start Program is determined by a review of pertinent records, information obtained from parental observation and report, and an evaluation administered by qualified personnel. If your child is determined to be eligible, you have the right to appropriate early intervention services. You have the right to provide information throughout the process and are encouraged to make decisions about your child's early intervention services. Procedural safeguards make certain that children and their parents or guardians are provided their rights under the law.

As a parent or guardian, you have the right to:

1. Be given the opportunity to begin the evaluation and initial assessment process.
2. Within 45 days after the referral of your child to a Regional Center or a local education agency, the evaluation and assessment activities must be completed and an Individual Family Service Plan (IFSP) meeting must take place to develop the IFSP.
3. Review the procedures and tests used in the assessment and evaluation.
4. Provide written permission before any evaluations or assessments are administered and refuse any evaluations, assessments and early intervention services.
5. Be fully informed of the results of evaluations and assessments.
6. Have access to records, including the right to examine and obtain copies of records relating to your child, and the right to request an amendment of records of any participating agency relation to your child.
7. Have an advocate assist you in dealing with the early intervention system, including Regional Center and local education agencies.
8. Obtain independent assessments and evaluations.
9. Have personally identifiable information maintained in a confidential manner.
10. Request a due process hearing to challenge the findings of any evaluations or assessments.
11. Attend a meeting to develop an IFSP within 45 days from referral.

Evaluation means the procedures used by appropriate, qualified personnel to determine your child's initial and continuing eligibility for early intervention services under the Early Start Program. These procedures require that:

1. Evaluation and assessment materials are administered in the native language of a child's parent/family or other mode of communication, unless it is clearly not feasible to do so.
2. Evaluation and assessment procedures and materials are selected and administered so as not to be discriminatory by race, sex, culture, or disabling condition.
3. Evaluation and assessment materials shall be appropriate for the specific purposes for which they are being used.
4. Evaluations and assessments are conducted by qualified personnel.
5. Evaluations or assessments administered to individuals with known visual, hearing, or communication impairments shall be selected to accurately reflect the individual's aptitude or achievement level, whichever factor is the subject of measurement.
6. Evaluation and assessment materials shall be designed to assess the specific areas of development and/or educational needs and not be designed to provide solely intelligence quotient measurement.
7. Assessments and evaluations are administered in the five developmental areas, including, where appropriate, health and development, vision, hearing, motor abilities, language functions, and social and emotional status.

Please Keep For Your Records.

Individualized Family Service Plan (IFSP)

If your child is determined to be eligible for early intervention, a meeting to develop your IFSP must take place within 45 days of your referral to a Regional Center or a local education agency. You have the following rights in developing and implementing the IFSP.

The right to:

1. Attend the meeting and participate in determining eligibility and developing the IFSP.
2. Request the attendance of other family members.
3. Request the attendance and participation of an advocate at the IFSP meeting.
4. Have the contents of the IFSP fully explained in your native language.
5. Give specific consent to each service listed on the IFSP. If you do not give consent to a service, it will not be provided. You may withdraw consent after initially receiving a service.
6. Provide concurrence to an assessment of your resources, priorities, and concerns regarding enhancing the development of your child.
7. Be notified in your native language and in advance, before an agency or service provider proposes or refuses to initiate or change the identification, evaluation, assessment, or educational placement of your child, or the provision of appropriate early intervention services to your child or your family.

Consent to the transmission of information about your child to the local education agency during transition to services under Part B of IDEA.

Administrative Proceedings

Parents may file written complaints regarding evaluation, assessment, placement, or service provision issues described above. Any parents involved in an administrative resolution of a complaint have the right to:

1. Be accompanied and advised by counsel and by individuals with special training with respect to early intervention services for children under age three.
2. Present evidence and confront, cross-examine, and compel the attendance of witnesses.
3. Prohibit the introduction of any evidence at the proceeding that has not been disclosed to you at least five days before the proceeding begins.
4. Obtain a written or electronic verbatim transcription of the proceeding.
5. Obtain written findings of facts and decisions within 30 days from the date the complaint is filed.
6. Have all personally identifiable information maintained in a confidential manner.
7. Require that the proceeding is carried out at a time and in a location which is reasonably convenient for you.
8. Bring civil action upon the other party in the complaint following completion of the proceedings.

Early Start Complaints

If a Regional Center, local education agency or private service provider violates a federal or state law or regulation governing the provision of early intervention services, you have the right to file a complaint directly to the Department of Developmental Services at the following address:

Department of Developmental Services
Office of Human Rights
Attention: Early Start Complaint Unit
1600 9th Street, Room 240, MS2-15
Sacramento, California 95814

The complaint should be in writing and include the following information:

- Name, address, and phone number of the complaint
- A statement that a Regional Center, local education agency or service provider has violated a federal or state law governing the provision of early intervention services
- A statement of facts upon which the allegation is based
- The allegedly responsible party
- A description of the voluntary steps taken at a local level to resolve the complaint, if any

North Los Angeles County Regional Center

9200 Oakdale Ave., Suite 100
Chatsworth, CA 91311
(818) 778-1900

43210 Gingham Avenue
Lancaster, CA 93535
(661) 945-6761

25360 Magic Mountain Parkway Suite 150
Santa Clarita, CA 91355 (661) 775-8450

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

_____

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.

2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.