

**Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program**

BILINGUAL EVALUATION JUSTIFICATION

Child's Name _____

The enclosed evaluation(s) is considered to be bilingual due to the following: (Check where appropriate)

The MDE / Supplemental Evaluation(s) was performed in _____
(Second Language)

Evaluation(s) / Discipline(s) (1) _____ (2) _____

Name/Title of Evaluator(s) (1) _____ (2) _____

OR

An *interpreter** was present during the MDE / Supplemental Evaluation(s) to assist a monolingual evaluator and the family with the evaluation process.

Name of Interpreter _____

AND

The written / oral summary of this evaluation was provided to the family in the dominant language or other mode of communication of the parent.

To the extent feasible and with the parent's preference, consent and confidentiality requirements, the written/oral summary of the evaluation must be provided in the dominant language or other mode of communication of the parent.

Parent requested English Summary Narrative Parent requested **non-English** Summary Narrative

Parent Signature to the Above Choice

_____/_____/_____
Date

If written summary not feasible, please explain:

* An interpreter interprets the spoken word either from one language to another, or to another mode such as sign language. Family members should not be used as interpreters unless absolutely unavoidable. Additionally, siblings should not be asked to take on the role of explaining a sibling's disability to his/her parent.

Signature/Title of Person Attesting to the Above

Agency (if applicable) of Person Attesting

_____/_____/_____
Date