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 _____
(Dominant/Native 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 summary of this evaluation was provided to the family in the dominant/ native language or other mode of communication of the parent.

_____ _____/_____/_____
Parent Signature **Date**

If the dominant language of the child is not the dominant language of the parent/guardian, the written summary is not required in the child's dominant language.

** 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**