

The SUNSHINE Project provides consultation services to early childhood educators and caregivers in support of children 0-5 enrolled in a Buncombe County child care program. Utilizing the Pyramid Model framework, we provide education and technical assistance to programs who have identified individual children experiencing challenging social/emotional behaviors, potential developmental delays, and/or special needs.

● **Once the referral is made, consultants will:**

1. Collaboratively design action plans based on caregiver/teacher information, screenings, observations, and the Pyramid Model framework
2. Provide individualized support such as:
  - Offering coaching/modeling for staff
  - Providing materials as needed (visuals, sensory, social stories, etc.)
  - Advocating for families by linking them with community resources
3. Conduct trainings based on the CSEFEL Model (Center on the Social and Emotional Foundations for Early Learning)
4. Facilitate team meetings, coordinate scheduled time for reflective feedback, and monitor progress

● **Consultants are not therapists and may not:**

- Provide one on one behavior support
- Count in ratio or be responsible for the classroom
- Be held accountable for the follow through of recommendations or strategies

● **Director's consent:** I understand that the SUNSHINE Project provides consultation services to early childhood educators and caregivers in support of children 0-5. Furthermore, it is my responsibility to monitor and be accountable for the follow through of the recommendations/strategies provided by the SUNSHINE Project consultants. I understand that I will be contacted 6 months after the referral has been closed, to discuss the enrollment status of the referred child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

● **Caregiver's consent:** I give permission for \_\_\_\_\_  
to participate in services provided through the SUNSHINE Project. YES  NO   
be photographed/videotaped for consulting purposes. YES  NO   
I give permission for SUNSHINE Project to exchange and/or share information with  
\_\_\_\_\_ (School System, CDSA, Therapist, Pediatrician, Service Provider)

Signature \_\_\_\_\_ Date \_\_\_\_\_

check here if you do not want to be added to our e-newsletter. FIRST does not share emails with anyone ever.

**Please contact our office at 277.1315 if you have not gotten a call from us within 2 weeks.**

### Child Referral Information

Date of Referral: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnicity:  Hispanic or Latinx  Not Hispanic or Latinx

Race:  American Indian or Alaska Native  Asian  Black or African American  Multi-racial  
 Native Hawaiian or Other Pacific Islander  White  Other  Decline to Answer

Language Spoken: \_\_\_\_\_ Interpreter requested:  Yes  No

Child lives with:  Parent/guardian  Other Family Member  Foster Parents  Other

Caregiver/Legal Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person/Agency referring: \_\_\_\_\_ Phone: \_\_\_\_\_

Childcare Center: \_\_\_\_\_ Phone: \_\_\_\_\_

Email of Center: \_\_\_\_\_ Teacher(s): \_\_\_\_\_ NC Pre-K?  Yes  No

● **Primary Concern (Please be specific):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Center Requests (check):

- Classroom Observations
- Connecting Child/Family with Community Resources
- Developmental/Social-Emotional Screening
- Materials (social stories, sensory items, visuals)
- Staff Coaching
- Other \_\_\_\_\_

Does child have:  IFSP  IEP Have a copy?  Yes  No

Child's Insurance:  Medicaid  Health Choice  Private (Type) \_\_\_\_\_

● **Please share any additional information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_