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 □ individualized Therapy □ Other __________________________

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

Child’s Insurance: □ Medicaid □ Health Choice □ Private (Type) __________________________

● Please share any additional information: __________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________