

Clinical Instructions

Wisconsin's

Functional Eligibility Screen

Children's

Long-Term Supports



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Division of Long Term Care
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Wisconsin Children's Long-Term Support Functional Screen Clinical Instructions

MODULE #1: Overview of the Children's Long-Term Support Functional Screen (CLTS FS)

1.1 Introduction

The Wisconsin Children's Long-Term Support Functional Screen (CLTS FS) was developed by a Department of Health Services (DHS) workgroup over the course of three years (2001 - 2003), as part of the Wisconsin's Children's Long-Term Support Redesign project. The goal of the redesign project was to improve access, coordination, choice, quality, and financing of the long-term support system to better serve children and families.

The CLTS FS was built upon the success of Wisconsin's Long-Term Care Functional Screen (LTC FS) which determines eligibility for most of Wisconsin's adults with long-term needs, frail elders and people with physical and developmental disabilities. Based on testing from 2003-2005, the CLTS FS has proven extremely accurate and reliable. Beginning April 1, 2005, the CLTS FS now provides functional eligibility determinations for six programmatic areas, four functional levels of care (explained below) and multiple target groups for children from birth through 21 years of age. For more information related to the screen's reliability and validity, training to become a certified screener, and reference materials for certified screeners, see <http://www.dhs.wisconsin.gov/LTCare/FunctionalScreen>.

The CLTS FS shares the same secure web-based infrastructure as the LTC FS, and adult Mental Health screen, however, the CLTS FS functions independently of these screens and is more complex because:

- It appropriately adjusts questions for children as they develop from birth through young adult (until age 22 years);
- It determines functional eligibility for multiple long-term support programs;
- It determines multiple levels of care and target groups; and
- Specific diagnoses are required for functional eligibility for some programs.

The CLTS FS has been designed, operated, evaluated and improved through a rigorous quality management system. The CLTS FS was designed with skilled clinicians from each of the programmatic areas, as well as others with experience related to child development. The initial success of the screen is attributed to the willingness of program staff, as well as county agency partners, to build and test the screen throughout its development. Extensive validity testing and inter-rater reliability testing was completed with these state and county partners. The testing results demonstrate that the screen provides accurate functional eligibility results across multiple levels of care as well as six programmatic areas. Although formal start-up testing of the CLTS FS is complete, processes have been established to try and prevent a child from being wrongfully denied functional eligibility. State staff continue to: address screener questions, review questionable functional eligibility results, provide ongoing quality oversight, develop screen changes, develop clear written instructions, provide comprehensive training to new screeners,

offer daily support and on-going training for certified screeners and notify screeners of changes or improvements to the screen in order to maintain a high level of validity and reliability.

Maintenance and improvement of the functional screen is an interactive process. Continuous quality improvement includes ongoing discovery activities including random reviews of individual children's screens related to accuracy and documentation related to the screener's responses, an analysis of individual screens and data, for example comparing screen functional eligibility to previous functional eligibility determinations, as well as trend and aggregate data to determine if screen results remain consistent and reliable. These efforts assure that screen issues are identified and corrected in a timely manner.

The components of the CLTS FS are as follows:

- **Individual Information:** Screen identifying data, child's demographic information, residential setting, legal concerns, and citizenship and identity verification;
- **Contact Information:** Contact information for child's parents, guardians and other significant individuals;
- **Diagnoses:** Child's diagnostic information pertaining to a disability determination, transplant, diagnoses, and primary care physician;
- **Mental Health:** Mental health status information regarding duration of condition, severe symptoms, needed services, rare and extreme circumstances;
- **Behaviors:** Listing of relevant behaviors to indicate frequency, intervention and duration. Behavioral categories of High Risk, Self Injurious, Aggressive/Offensive and Lack of Behavioral Controls;
- **Activities of Daily Living:** Specific items available to indicate need for support in bathing, grooming, dressing, eating, toileting, mobility and transfers. Provided by specific age groups;
- **Instrumental Activities of Daily Living:** Specific items available to indicate need for support in communication, learning, social competency, meal preparation, and money management. Provided by specific age groups;
- **School and Work:** School attendance and compliance, high school related data, support needed to transition to adult services, employment information and preferences.
- **Health Related Services:** Medical and skilled nursing information including terminal conditions, tracheostomy, ventilator, dialysis, IV, oxygen, respiratory treatments, TPN, tube feedings, therapies, colostomy, catheter and wound or site care.

The CLTS FS also includes additional information not directly related to the functional eligibility of the child. These other factors have been added to track critical national outcome data in areas such as the child's status with a primary health care provider (a Medical Home) and Transition planning services and supports.

The CLTS FS provides the opportunity for certified screeners to describe the needs of children with long-term support needs living at home, in substitute care settings, or in institutions as these factors relate to functional eligibility required for various children's long-term support programs. The following are the "screen development criteria" that guided these decisions:

- **Objectivity and Reliability:** The CLTS FS is designed to be as objective as possible in order to reach the highest possible "**inter-rater reliability**" (two screeners would answer

the same way for a given child). Subjectivity is minimized to ensure fair and proper functional eligibility determinations, as well as to improve statewide consistency.

- **Accuracy:** Functional eligibility determinations must be correct and must match current accurate decisions, in **every** instance.
- **Brevity:** The CLTS FS only determines functional eligibility to as it relates to the level of care criteria associated with each program's eligibility. It serves as a baseline for more in-depth assessment to develop a service plan that reflects each child's and family's strengths, values, and preferences.
- **Inclusiveness:** Children of all ages; with emotional, cognitive, physical, or developmental disabilities; with or without skilled nursing needs; in any setting from homeless to hospitals or institutions; can be accurately screened with the given choices for each developmental and activity subsection.
- **Clarity:** Definitions and answer choices, including diagnoses and nursing needs, must be clear to screeners with a broad array of professional backgrounds and experiences.

1.2 The CLTS FS Determines Functional Eligibility for Long-Term Support Programs

The CLTS FS determines functional eligibility for people from birth to age 21 years inclusive, and where relevant, a specific "Level of Care," and Target Group (explained below) for seven different programs:

- Comprehensive Community Services;
- Community Recovery Services;
- Community Options Program;
- Family Support Program;
- Katie Beckett Medicaid TEFRA Program;
- Medicaid Home and Community-Based Services Waivers; and
- Mental Health Wraparound Services.

The Centers for Medicare and Medicaid Services (CMS) requires that "Target Groups" not be combined within one waiver. Therefore, there are three complimentary CLTS Home and Community-Based Services Waivers (Developmental Disabilities, Physical Disabilities, and Mental Health).

The screener will collect relevant functional eligibility information in the course of meeting a child and their family. Again, the CLTS FS is **not** a comprehensive assessment; rather it is a review of key information related to functional eligibility. Once the CLTS FS fields are complete, the computer functional eligibility logic is able to determine Hospital (HOS), Psychiatric Hospital (SED), Nursing Home (NH), and Developmental Disability (DD) Level of Care (LOC) for both Medicaid Home and Community-Based Services Waivers and the Katie Beckett Medicaid Program. Additionally, the related Target Group(s): Physical Disability, Mental Health or Developmental Disability, for the CLTS Home and Community-Based Services Waivers is determined.

The CLTS FS also provides a functional eligibility determination for the Family Support Program, Comprehensive Community Services, Community Recovery Services, Community Options Program, and Mental Health Wraparound. The screener does not need to select

program(s) for which they want to determine functional eligibility. The screen automatically reviews the child's functioning in comparison to functional eligibility criteria for all programs. Functional eligibility results may show that a particular child meets functional eligibility for some programs but not functional eligibility for other programs. The CLTS FS **does not determine program eligibility**, only one piece of program eligibility (functional eligibility).

If functional eligibility results do not seem appropriate to the screener based on their knowledge of the level of care requirements and their knowledge of the child's abilities, or if the screener has any screen completion questions, the screener must let the CLTS FS Clinical Advisor know. This is critical to the accuracy and reliability of each individual Functional Screen.

If the person is seeking Adult Long Term Care Programs, the Adult Long Term Care Functional Screen should be used to determine functional eligibility. For other programs that provide support to young adults from 18-22 years of age, the screener should select the screen that best matches the types of services the person is seeking from the waiver. For example, if the needed services are primarily adult related or administered programs, then the adult functional screen should be used.

The Functional Screen tools are intended to streamline initial and ongoing functional eligibility determinations and to reduce duplicative efforts. Therefore, when a person is within the transitional ages of 18 to 22 years of age, programs will accept the results from the most appropriate functional screen. For example if a person is 19 years old and using one of the Medicaid CLTS Waivers, then the CLTS FS should be used for this as well as other programs such as COP and FSP. If another 19 year old is using the Medicaid CIP Waiver, then the Adult LTC FS should be completed and these results will serve as results for COP and FSP.

Social Security Disability Determination

A child must have a Social Security Administration (SSA) determination of disability for the Katie Beckett Medicaid Program and most Medicaid Home and Community-Based Waivers eligibility. If a child has a confirmed disability determination the CLTS FS will issue actual functional eligibility results. If the child has not had such a determination, or if their disability status is unknown, the screen will display "pending a disability determination" on the eligibility results page.

Other Functions of the CLTS FS

The CLTS FS gathers and stores all information collected in the functional screen process. These data serve purposes in addition to an individual child's determination for program functional eligibility. The data also:

- Serve as a foundation for the comprehensive assessment related to long-term supports and services selected by the parent(s).
- Provide data for quality assurance and improvement studies for the Department of Health Services (DHS) and long-term support programs utilizing the CLTS FS.
- Provide data to counties and, as appropriate, to provider agencies on eligible children and on encounter data and timeliness of the eligibility process.
- Provide data for national and state-level outcome measurements.

1.3 The CLTS FS is Required for Long-Term Support Functional Eligibility Determinations

Parent(s) should provide informed consent to participate in providing information for a functional screen functional eligibility determination. This includes the requirement that all information provided must be accurate and truthful and that failure to be accurate and truthful has consequences. The parent(s) may refuse to provide needed information and may refuse to have a CLTS Functional Screen completed. However, the consequence of this decision is that the child may not be able to access Medicaid and long-term support services. The parent(s) should also be informed that information gathered during the screening process is confidential, that information will be submitted to DHS for aggregate data analyses and that information may have an affect on their functional eligibility or ineligibility for other programs. No screen should be completed without the parent(s) consent.

Screening agencies shall comply with confidentiality and Health Information Privacy Protection Act (HIPPA) rules and requirements, and shall obtain a signed release of information from the child's parent(s) or guardian(s) for the use of medical records, educational records and other records as appropriate before conducting the CLTS FS. Signed releases of information shall be included in the child's records when appropriate.

Confidentiality

Any information collected for the screen or during the screening process is confidential. Information is to be treated with the same requirements for confidentiality within the current system of long-term supports. If one agency completes the screen but the family wants the results to be considered by another relevant long-term support system, separate consent to share confidential information may be required.

Example: A family contacts the Family Support Program to apply for these supports and services. In the course of completing the screen, it appears that the child will also be COP and Medicaid Home and Community-Based Services Waiver eligible. The CLTS FS information can be shared between members of the same agency on a need-to-know basis. However, if the lead agency for COP or the Waiver is different, a release of information will need to be obtained from the family before access to CLTS FS information is granted to a different agency. In addition, the screener can only share with the family the screen results for the long-term support program that their agency administers.

All information can be viewed at the state level on a need-to-know basis. This includes quality management activities at an individual and aggregate level. As part of the initial consent process, parent(s) will be informed that information entered into the screen will be entered into a state level system. However, these results will only be viewed at an individual level when there is a need-to-know.

1.4 The Screening and Interview Process

The screening process requires face-to-face contact with the child being screened. Ideally, the required face-to-face interview should take place in the family's home with the child present.

This home-based visit is required if the family is applying for the Katie Beckett Program. It may take more than one contact with the child and parents to complete the CLTS FS.

There is a paper version of the Functional Screen. This is intended as a reference tool only. The paper version is not intended as an interview guide or application form for families. Certified screeners may use existing agency application and assessment forms to assist them in collecting necessary information about the child's and family's strengths and needs. The CLTS FS sections can be completed in any order within the web-based application. This facilitates the use of the screen with a variety of existing application forms and assessment tools.

The certified screener should use their clinical interview and assessment skills to gather the needed information to complete the CLTS FS. The screener will need to ask questions in a variety of ways and use collateral informants as necessary. Collateral informants include other family members, Birth to 3 Program or school staff, formal or informal caregivers, health care providers, and other agencies serving the child. The screener must always have a face-to-face contact with the child, even if other informants are used.

Once the screener gathers all needed information, the CLTS FS is completed using the web-based application. Entering information into the CLTS FS is completed separately from the interaction with the family and child. It is critical that the certified screener's responses are accurate and verified from a variety of sources as necessary. The screener must strive to use objective clinical judgment and this could be affected by completing the screen with the family present. The CLTS FS is a tool for certified screeners to ensure smooth and timely access for the child and family to long-term supports. It does not replace strong clinical and interaction skills to form a relationship with the child and family.

1.5 Screening and Re-Screening Requirements

The Medicaid Home and Community-Based Services Waiver, the Katie Beckett Medicaid Eligibility Program and the Family Support Program require an INITIAL screen to establish functional eligibility prior to receiving services. A RESCREEN, or recertification, is required thereafter to ensure continued functional eligibility.

It is critical, whenever the condition of a child enrolled in a long-term support program substantially changes, that the CLTS FS be updated using a RESCREEN and the functional eligibility logic recalculated. This will determine whether or not the child's change in condition impacts their level of care, target group or functional eligibility by program.

The CLTS FS can be done more often than yearly. This includes whenever a screen is transferred, the child's condition changes or other important changes need to be documented. It is important that when a RESCREEN is done, that the screener review the child's previously completed screens for information and historical perspective. The data warehouse maintains all information from previously calculated screens so that the longitudinal perspective is preserved when a new version of the screen is created.

1.6 Reliability of Screen and Screeners

The CLTS FS has been established as a reliable functional eligibility tool when used by certified screeners who follow established policies and procedures including verification of diagnosis, health related services, activities of daily living and instrumental activities of daily living. Because a child's developmental functioning and expectations change as the child ages, extra vigilance to ensure the greatest possible accuracy in the CLTS FS must be utilized.

Screeners should adhere, at a minimum, to the following guidelines:

- Read and follow screen definitions and instructions closely. Screeners are notified whenever changes or updates are made to the screen or instructions. Screeners are responsible to adapt their use of the CLTS FS per these instructions.
- Address each question carefully to assure accuracy, even when a screener knows a child well.
- Always select the answer that most accurately describes the child's functioning. The functional eligibility logic is very complex and uses information gathered from all sections of the CLTS FS. Therefore, it is important that a screener not second guess how their responses may interact for a particular child.
- Do not alter a response to any particular question in an attempt to make a child functionally eligible or ineligible. The response to a single question will not give specific results. Rather the screen logic compiles all responses and compares this to functional eligibility, level of care and target group information. If a screener gets an unexpected result for any of these areas, the CLTS FS Clinical Advisor must be contacted.
- Refer all questions and concerns to the CLTS FS Clinical Advisor. This assures consistent interpretation of the CLTS FS. Consistent responses are critical for ongoing inter-rater reliability. Changes and corrections as a result of questions are then communicated to all programs utilizing the CLTS FS. This information may also lead to revisions in the CLTS FS assuring ongoing quality improvement.

1.7 Requirements for Quality Assurance and Screener Qualifications

As discussed above, the CLTS FS determines a child's functional eligibility for Wisconsin's long-term support programs, including:

- Community Options Program
- Community Recovery Services
- Comprehensive Community Services
- Family Support Program
- Katie Beckett Medicaid Program
- Medicaid Home and Community-Based Services Waivers
- Mental Health Wraparound Services

Special requirements for quality assurance and screener qualifications are necessary because the CLTS FS helps determine functional eligibility. The screener must have experience regarding the unique conditions, development, needs, and functioning of children with significant disabilities. The screener must also complete training to be a certified screener, as well as on-going review of their reliability as a screener.

Parallel to the screener qualification, training, and certification requirements stated above, there are quality performance and assurance requirements to ensure consistency and accuracy of administration of the screen. There are three levels of CLTS FS quality assurance.

1. **Individual Screener Quality Assurance Review.** It is the screener's responsibility to be objective in screening, to be informed of the instructions, and to corroborate information gathered from the child's family. The CLTS FS Clinical Advisor can address questions that arise as a screener completes an individual child's CLTS FS. Screeners should contact the CLTS FS Clinical Advisor whenever they obtain a different result than expected for a child based on the requirements of the level of care criteria. This includes functional eligibility and non-eligible results, as well as any discrepancy in the expected target group or level of care. Screeners should also seek clinical consultation on any individual screen question that is complex or confusing for a given child's circumstances. Screeners are held accountable for their results. This could result in a disallowance of state or federal funding and resulting recoupment.
2. **Agency Level Quality Assurance Review.** Agencies are held accountable for the accuracy of all screens completed by their staff. Inaccurate and poorly completed screens or screens manipulated for a particular outcome may result in a disallowance of state or federal funding and resulting recoupment.

The methods each agency should be conducting will, at a minimum, include:

- Participating in all required inter-rater reliability testing;
- Assuring appropriate training, mentoring, and monitoring of new screeners;
- Reviewing a random sample of CLTS Functional Screens for accuracy and consistency on an on-going, agency-wide basis;
- Completing all required reports;
- Following up on all quality assurance inquiries and providing proof of proper documentation for all responses on the CLTS FS; and
- Consulting with CLTS FS Clinical Advisor regarding any screen results or inaccuracies discovered through these activities.

3. **State Level Quality Assurance Review.** The Department of Health Services reviews screens and utilizes quality assurance methods during quarterly and annual reviews. This includes a series of analyses and comparisons of all agencies' screens. Each agency receives a report following such reviews, including a request to the screening agency to correct and amend any screen errors or inconsistencies.

1.8 Screening Limitations

Research shows that the following limitations occur in all functional assessments or screens:

- Self-reports (from children or parents) can be inaccurate.
- Different people will describe a child's abilities, needs, and problems very differently.
- People often provide different information at different times and/or to different screeners.
- People may observe different functional abilities and needs over time or across different settings (e.g., home or school), making it difficult to select an accurate answer.

- Screen answers vary somewhat depending on whether the screener knows the child.
- Screen answers vary somewhat depending on the environment in which the screener observed the child.
- While objectivity is the ultimate goal, some subjectivity may remain in some questions.

Strategies to Minimize Screening Limitations

This section outlines guidelines to increase inter-rater reliability of the CLTS FS despite the limitations noted above.

A. Apparently Inaccurate or Inconsistent Reports

Functional eligibility screens cannot be based solely upon child or family self-report; nor can they be merely screener’s judgment. Both of these extremes allow for too much subjectivity. The goal of the CLTS FS functional eligibility process is to be as objective as possible. When screeners are objective, the result is high “inter-rater reliability”--meaning that other screeners would choose the same answer as another screener. Each screener must gather as much information, objective data, as possible, and then ask, “Given all this information, what would other screeners choose for an answer?”

When meeting with a child and their family, asking questions, asking for demonstrations, and observing evidence carefully provides additional objective information. The screener can be curious, rather than critical, about the reasons people respond to the functional performance inquires with differing responses. A screener is often touching upon the emotions and needs of the child and family. Emotions and needs may affect an individual’s perspective and therefore their answers. A certified screener with experience working with children and families must apply this awareness and interview expertise to assure an accurate CLTS FS result.

If further questions and observations don’t indicate a clear answer for the CLTS FS, the screener should look for and consider additional information from health or school records plus other care givers or professionals

In summary, screeners should follow this three-step process:

1. Ask more questions and rely on their expertise in interview and observation. Ask the family or child for additional details or perhaps a demonstration of a skill. Consider the whole picture, to see if the “pieces” make sense.
2. Seek additional information from other people such as the other parent, teachers, therapists, physicians and other people who interact with the child in a variety of settings.
3. Ask, “Given all this information, what would other screeners choose for an answer?”

If still not clear, refer the question to State Clinical Staff.

B. Different Descriptions from Different People

Different people can describe a child’s abilities, needs and problems very differently. This is expected due to varying perspectives among reporters, and because children often act differently in different settings or even with different people. Parents’ perspectives and knowledge often are very different from that of a professional who sees the child only once a week. Children may in fact act very differently at school and at home. Adults’ opinions, values, stresses, coping abilities

and risk factors all affect how those adults describe a child's needs and behaviors. Cultural values and expectations can also create differences in how people perceive and describe a child.

The screener will consider all available information, such as health or school records. Then ask, "Given all this information, what would other screeners choose for an answer?"

During a screening, parent(s) may convey a wide variety of emotions and attitudes. The certified screener's role is to recognize and respond to those feelings and perceptions and to help describe a child's abilities as accurately and objectively as possible. The screener must be aware of the affects of stress, interpersonal relationships and family dynamics on a person's perception of a child's behaviors and needs. Professional opinions do not override parents. Rather a screener must address parents' views and engage with interest and questions that gently focus on objective information about the child. Here again is the three-step process to follow:

1. Ask more questions and rely on observation. Ask for details, perhaps a demonstration. Consider the whole picture, to see if the "pieces" make sense.
2. Seek additional information from other people such as the child's other parent, teachers, therapists, physicians and other professionals.
3. Ask, "Given all this information, what would other screeners choose for an answer?"

C. Abilities Fluctuate

The CLTS FS is a functional eligibility tool; it is not a complete assessment of a child's current status. Screeners are currently allowed to add additional notes to serve as an assessment, but this is not the purpose or structure under which the CLTS FS was created or implemented. The CLTS FS is a broad baseline of information and it not formatted or constructed to serve as an individualized comprehensive assessment tool In addition, the screening tool addresses certain specific areas of skill and development relevant to functional eligibility criteria. It does not include many areas that would be included in assessment and service plan development activities. Therefore, if the screener is using the CLTS FS also as an assessment tool it may make it more difficult for the screener to choose the most accurate answer on the CLTS FS.

Responses to ADL/IADL, mental health and behavioral questions have different frequency requirements. These requirements are described in the instructions for those sections.

Remember that the screen is taken in total; even if some ADLs are not checked, the child could be eligible through different sections of the CLTS FS.

1.9 Impending Discharge Back to Home

When screening a child who will be discharged within approximately one week from a skilled health care facility, for example a hospital, an Intermediate Care Facility for Mental Retardation (ICF-MR), a State Center for Developmental Disabilities or an Institute for Mental Disorders (IMD), complete the screen based on how the child is expected to function upon their return home. This looking ahead is a normal part of discharge planning. If, for example, oxygen and intravenous (IV) will be stopped before the child goes home in two days, do not mark "IV" under treatment on the HRS portion of the screen. If the family is learning to do a two-person pivot transfer to prepare to use at home, indicate that the child needs assistance with transfers on the ADL portion of the screen, even if now the hospital does one-person transfers with a mechanical

lift. The screener will need to gather additional information from facility staff and the child's parent(s) to get the most accurate picture of the child's needs at home, after discharge.

The screener must be able to envision the child at home. Therefore, the screener must have experience in community care for the target group being screened. The CLTS FS should be redone shortly after the child goes home, if the child's condition or situation changes from what was expected at the time the screen was initially completed.

MODULE #2: Informational Pages

2.1 Identifying Information

When searching for a child or entering the information for a New Applicant into the CLTS FS, the child's name, date of birth and Social Security Number are critical items for identification. They must be entered accurately. If a child is not a client in the CLTS FS and the screener must add them as a New Applicant, the system will check other databases to see if the child exists in other systems in order to link data for accuracy. If the system identifies some or all of this identifying information for a child, it will report back optional clients to select in order to proceed. If one of those clients matches the child the screener is entering as a New Applicant, especially if there is a 90% or better match of this identifying information, the screener should select that client and proceed.

The identifying information is initially entered when adding a client to the system. It is updated or changed on the Individual Information page. If there is an error, or a screener needs further assistance with this process, contact the DHS SOS Help Desk. The DHS SOS Help desk's email is: DHSSOSHelp@wisconsin.gov.

Name

If the child has a "Jr." or "IV", or other suffix added to their name, list this in the Last Name box, following their last name.

Name Change / Name Misspelled

If the child's name has changed, often due to an adoption, or a screener notices that the name has been misspelled on the screen, the name can be changed on the CLTS FS. Select the screen with the child's previous name and update the information contained on the Individual Information page of the screen. This updated information will be saved for future screens but the information will not affect previously calculated screens.

Date of Birth

Enter the child's date of birth in **MM/DD/YYYY format**, as in 01/01/2011. A calendar option is available to improve accuracy. CLTS FS programming will not allow dates to be entered that make the applicant more than 22 years old. The person should be referred for an adult screen in this instance. The date of birth must be earlier than the Screen Begin date.

Social Security Number

Enter the child's Social Security Number (SSN) in the **###-##-####** format. Only enter the SSN as it appears on the government issued Social Security Card in the child's name.

Pseudo Social Security Number

The **only** time a certified screener should select to use a Pseudo Social Security Number (SSN) is when the child does not have an actual SSN issued at the time of the home visit (e.g., newborn infants). Do not use a Pseudo SSN simply to enter a screen prior to learning the child's actual SSN.

When a Pseudo SSN is used, the child's identifying information does not go through the MCI clearance. Therefore, if you have a SSN but question the accuracy of it, use the SSN provided to you and then the MCI can check to see if it is a match to another SSN listed for the child.

If a previous screener used a Pseudo SSN and you now have the child's actual SSN, please make the necessary correction in two places. First, uncheck the Pseudo SSN box on the Individual Information page and then enter the correct SSN on that page.

SSN Status

The child's SSN Status displays the system's understanding of the information entered in the Social Security Number field. If the child is already known to the system, their status will read "Verified SSN". If it is a new SSN, the status will initially be "Unverified SSN". It typically takes the system 7-10 days to verify a child's social security number. Other possible options are indications of a miss-match of information involving the child's name, date of birth and SSN.

Social Security Number Entered Incorrectly

When a screener identifies that a social security number has been entered incorrectly, the error must be corrected internally. Contact the DHS SOS Help desk with the child's full name, incorrect social security number and correct social security number. The DHS SOS Help desk's email is: DHSSOSHelp@wisconsin.gov. This is a very costly error and should be avoided.

Duplicated Screens

If there is more than one functional screen for the same child, the additional screens can only be merged together through support from the DHS SOS Help desk. This is a very costly and manual process and should be avoided. The screen to use, when multiple screens are available for one child, is the screen with the child's correct social security number. The screen with a pseudo or incorrect social security number should be the one that is deleted. Contact the DHS SOS Help desk with the child's full name, incorrect screen identification and correct screen identification. The DHS SOS Help desk's email is: DHSSOSHelp@wisconsin.gov.

Master Customer Index Identification Number (MCI ID)

The Master Customer Index (MCI) identification number is another form of identification for a child. It will appear on the Individual Information page next to the child's date of birth. This number is generated by the greater system. It is often, but not always, the child's Medicaid ID number.

2.2 Screen Types

The screener will select one option whenever they complete a CLTS FS. There are two screen types from which to choose: INITIAL and RESCREEN. The screen type relates to the reason or place a child is at regarding their relationship to a specific program for which the CLTS FS determines functional eligibility.

INITIAL SCREEN

The first CLTS FS completed for a child interested in accessing long-term support services is an INITIAL SCREEN. INITIAL SCREEN is also selected when a child has been enrolled in one program but is now initially applying for a different program. Likewise, if a child is on a waiting list and is now being screened for services or enrollment, an INITIAL SCREEN is selected and completed.

An INITIAL SCREEN is selected in the following four circumstances:

1. The very first time a screen is created for a new applicant. No previous screen exists for the child.
2. A child has a completed screen for one program but now is having their first screen completed for a different program.
3. A child has been on a waiting list for a particular program and is now coming off the waiting list for service delivery.
4. Any time a child was discontinued from a program or found Not Functionally Eligible for services and is now reapplying for the same program.

RESCREEN

A RESCREEN or recertification screen is required as long as a child is enrolled in a long term support program. This type of screen is usually required annually. RESCREEN is also used when a screener wants to accept the information entered by a previous screener and work off of that screen for their screening purposes.

EDIT

A screener may use EDIT to add or change information in a screen that they are currently working on. After six months has past, a screener must select RESCREEN rather than continuing to use EDIT to access the screen.

2.3 Screen Dates

Referral Date

The Referral Date is the date the screener received the initial request for service from a parent/guardian or another referral source.

Screen Begin Date

The Screen Begin Date is the date of the screener's first face-to-face contact with the child and parent(s).

The Referral Date and Screen Begin Date may be used to assess state and local systems for timely responses to families' requests for screening. The difference between the Referral Date and the Screen Begin Date will be tracked as part of quality improvements to ensure timely responses to requests for screening. This is quality improvement for *systems*, not individual screeners. For instance, if one county always takes, on average, three weeks longer than other counties, there may be local systems changes they can make to improve their response time. A Referral Date is only required on Initial Screens.

Screen Completion Date

The screener enters the Screen Completion Date as the date that they have entered all the required information into the CLTS FS and are prepared to calculate eligibility. The Screen Completion Date is recorded on the last page of the CLTS FS.

Screen "Determined On" Date

This is a system generated date that will report the actual date eligibility was calculated on the screen.

2.4 Screen Information

Screener's Name

The screener's name must be selected from the drop down box available on the screen. By selecting the screener's name, the email on file will be automatically displayed.

Referral Source

Select from the drop down box to indicate who contacted the screening agency to refer this person for a screen. The CLTS FS is designed to determine functional eligibility for children; therefore, we are seeking the referral source that recommended that the family contact the screener agency. Use parent as the referral source only if *no* other person prompted them to contact the screener. If another parent provided the referral to this family, then it is also appropriate to select "parent" from the drop-down options. A referral source is only required on Initial Screens.

2.5 Child's Information

Is this functional screen being completed for the purpose of determining Level of Care for a CLTS Waiver? *Answer "No" if a child is enrolled in a CLTS Waiver.*

This question distinguishes screens completed for application to state funded Children's Waivers versus those completed for other programs or for children already on a CLTS Medicaid Waiver. This is an important differentiation for purposes of reporting to CMS, Centers for Medicare and Medicaid Services.

If this functional screen is being completed for a child applying for a state funded CLTS Medicaid Waiver (PD, DD or MH), then answer this question "Yes". If this screen is being completed to move a child off of a waiting list and on to the CLTS Waiver, screeners will answer this question "Yes". If a child is receiving CLTS Waiver services, and the screen is being completed as part of the ongoing recertification process, then this question is answered "No". If the screen is being completed for any other program, this question is answered "No".

Address

Enter the child's "permanent residence" address. For transient persons, enter the address they lived at the most in the last six months.

If there is a street address and a PO Box, enter street address and apartment information on line 1, PO Box on line 2, and use the PO Box ZIP Code.

County/Tribe of Residence and County/Tribe of Responsibility

Select the appropriate county/tribe from the drop down box. Typically these will be the same entry. However, in a few instances, people may live in one county but another county/tribe is responsible for services, costs, and/or protective services. For the purposes of screening, residency is physical presence or the intent to reside. The CLTS FS program will automatically enter county of responsibility to be the same as county of residence. This "default" entry can be overridden if different counties are involved.

2.6 Living Situation

Current Residence of the Child:

Select the appropriate response from the drop down box. If the screener selects “other,” type an explanation in the “other” box. Most of the drop down box menu options are self-explanatory.

If a family is homeless but the child is under 18 years old and living with their parents, please select “with parents” for their living situation. If they are over 18 years old and homeless, then select “no permanent residence.”

If a child is living in a kinship care arrangement, select “with other unpaid family members.”

Number of residents (# of beds) certified for?

If a child lives in a multiple bed complex, indicate the number of beds for the license. This applies to the following living situations: Foster Care or Other Paid Caregiver’s home; Treatment Foster Home; Children’s Group Foster Home; Adult Family Home; Community Based Residential Facility.

If a child is in an out of home placement, answer the question, **Is the child expected to return home within 6 months of screening date?**

2.7 Legal Concerns

Are the child’s parents aware of the legal concerns (e.g. Guardianship, Power of Attorney, and Representative Payee) once the child turns 18 years old?

This is a required field once the child is 16 years of age. It is not necessary to know the family’s specific choice when the child reaches 18 years of age, since the intent of the question is whether or not they are considering the issues involved as their child becomes an adult.

Is the child, who is 18 years of age or older, their own guardian (i.e., s/he does not have a legal guardian)?

This is a required field once the child is 18 years of age. If the young adult does not require guardianship of person, they are considered a competent adult.

2.8 U.S. Citizenship and Identity

Per Federal regulations, United States citizenship and personal identity must be verified for any child seeking Wisconsin Medicaid eligibility which includes Medicaid funded Waiver services. The CLTS FS has required fields where the screener records the documentation viewed to verify both the child's U.S. citizenship and personal identity.

The U.S. citizenship and personal identity requirement applies to all children applying for or receiving services from a Medicaid funded program which includes the Katie Beckett Program and the Children's Long-Term Support Waivers. The Family Support Program (FSP), Community Options Program (COP) and MH Wrap Around programs do not require citizenship and identity documentation. The Comprehensive Community Services (CCS) program requires

participants to be Medicaid recipients prior to service provision so United States citizenship and personal identity will have already been verified through their application to Medicaid.

For more information regarding these procedures, refer to the Operational Memo 07-69 Citizenship and Identification Requirements Final Rule Summary, located on the State of Wisconsin DHS website at <http://dhs.wisconsin.gov/em/ops-memos/2007/pdf/07-69.pdf> and Acceptable Citizenship and ID Documentation, located at <http://dhs.wisconsin.gov/em/processhelp/PH68.3.pdf>.

Screeners must refer to this memo and related charts for clarification on specific, acceptable documentation. In addition, each program for which the CLTS FS determines functional eligibility must adhere to its own citizenship and identity regulations.

For U.S. Citizenship, the screen asks the following questions:

- Child has documentation to establish U.S. Citizenship.** The certified screener will be required to indicate from a drop down menu what documentation was used to verify U.S. Citizenship.
- Child does not have U.S. Citizenship but does have the following Alien Registration Number per the verified Permanent Resident Card.** The certified screener will be required to enter the 9-digit Alien Registration number.
- Child claims to have U.S. Citizenship or an Alien Registration Number but required documentation was not provided.** The certified screener will be responsible for updating this screen once the documentation is available.
- Child is only seeking eligibility for the Family Support Program, Community Options Program, Comprehensive Community Services, and/or Mental Health Wrap Around Program.**

Note that these options are mutually exclusive, that is, only one can be selected. As a result, if a screener is entering a screen where the first item (Child has documentation to establish U.S. Citizenship) has already been selected in the past, it should remain checked even if the current program they are applying for does not require U.S. Citizenship. For example, if a child has previously applied for Katie Beckett Program - Medicaid which requires U.S. Citizenship and the Katie Beckett Program certified screener selected the first option above and then the child applies for the Family Support Program (which does not require U.S. Citizenship), the Family Support Program certified screener should leave the first option selected to not negatively affect the child's eligibility for the Medicaid funded program.

If a Permanent Resident Card and/or Alien Registration Number is the documentation being used for Medicaid eligibility this requires further review. This review of Medicaid eligibility can only be done by a Nurse Consultant for the Katie Beckett Program or by a county Economic Support Unit (ESU) for all other Medicaid programs, such as the CLTS Waivers. Therefore, either the Nurse Consultant's name or the Economic Support Worker's name, plus the date this required eligibility was verified, must also be documented in the final notes section of the CLTS FS.

If the child is seeking a Medicaid funded program (Katie Beckett Program or CLTS Waiver) and the screener does not have documentation of U.S. Citizenship, the following warning will be posted:

U.S. Citizenship: You've checked that the child claims to have U.S. Citizenship or an Alien Registration Number but required documentation was not provided. It is your responsibility as a certified screener to change the U.S. Citizenship verification on the functional screen when the required documentation is obtained. If a child is awarded eligibility for a program without the required verification of documentation, your agency is at full risk for the full cost of services for this child without any federal matching funds.

The screen will also have the following pending results:

Not eligible due to lack of U.S. Citizenship documentation and verification. Services cannot be provided through this program without required documentation.

"Pending documentation" is available as an option under Identity and can be used when a screener has requested the necessary documentation but has not yet received it. The functional eligibility results will continue to indicate that verification is required.

"Not a Medicaid funded program" is available as an option under Identity. When a screener is completing a screen for The Family Support Program (FSP), Community Options Program (COP), MH Wrap Around or Comprehensive Community Services (CCS) they may select this option. If a screener completes a CLTS FS for a child who already has their identity verified by a previous screener, please do not change that information to "Not a Medicaid funded program", even if the program you are completing a screen for does not require the verification.

Once a child's U.S. citizenship and personal identity has been verified by the proper documentation, it does not need to be verified annually at recertification.

If screeners have further questions regarding verification of U.S. citizenship or personal identity requirements, please contact the Children's Services Specialist for your county or your specific program manager.

2.9 Ethnicity & Race Information

ETHNICITY

This is not a required field. If needed, use the following definition to identify the appropriate option:

- **Hispanic / Latino:** A person of Mexican, Puerto Rican, Cuban, Central, South American, or other Spanish culture or origin, regardless of race.

RACE

This is not a required field. Please check all boxes that apply. The choices here match federal insurance reporting requirements. If needed, use the following definitions to identify the appropriate option:

- **American Indian or Alaska Native:** “American Indian and Alaska Native” refers to people having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicate their race or races as Rosebud Sioux, Chippewa, or Navajo.
- **Asian:** Refers to people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. It includes people who indicate their race or races as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” or “Other Asian,” or as Burmese, Hmong, Pakistani, or Thai.
- **Black or African American:** “Black” refers to people having origins in any of the Black racial groups of Africa. It includes people who indicate their race as “Black,” African American, Afro-American, Nigerian, or Haitian.
- **Native Hawaiian or Other Pacific Islander:** “Pacific Islander” refers to people having origins in any of the original peoples of Guam, Samoa, or other Pacific Islands. It includes people who indicate their race or races as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” or “Other Pacific Islander,” or as Tahitian, Mariana Islander, or Chuukese.
- **White:** “White” refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “White” or as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

2.10 Interpreter Language Required

Leave this blank if no interpreter is needed. Select the appropriate language if an interpreter is needed. If “Other,” please type in the language needed in the space provided. Human service and health care providers should always obtain interpreters when they are needed. This information will help show the extent of such needs, and will also help long-term care programs better serve consumers whose primary language is not English.

2.11 Contact Information

Contact Information

For children under age 18, at least one “Contact” must be entered who has legal rights to the child’s records. For applicants 18 or over, if they are not their own legal guardian, then at least one “Contact” must be entered who has legal rights to the child’s records.

Parents must be entered separately as two different contacts. DHS correspondence will be sent to the first Contact listed.

In cases of joint custody in which one parent does not reside with the child, that parent’s contact information must be included. If the second parent does not have joint custody, this information is optional.

For convenience, the child's address and home telephone number will auto-fill if the screener selects "parent" as the type of contact. The screener can delete or write over this information if it is not correct for the contacts. If a contact person's name is not clearly gendered, the screener can note the person's gender in the Notes section for future reference.

If there is a street address and a PO Box, enter street address and apartment information on line 1, PO Box on line 2, and use the PO Box ZIP Code.

The home telephone number is a required field. If the person has no telephone enter all "zeros" (000) 000-0000.

If a contact person does not have a known address, put the person's name and any additional information the screener has in the note section on this page.

Has legal rights to child's record

For each contact listed, check this box if the contact has legal rights to the child's records. This will typically be the child's biological or adoptive parent(s) or guardian.

DELETE / ADD NEW

For any contact previously listed on a screen that is no longer an appropriate contact for the child, the screener can select the Delete button and that entire contact will be deleted. To add additional contacts, use the Add New button located towards the bottom of the page.

MODULE #3: Diagnoses

3.1 Has the child been determined disabled by the Disability Determination Bureau (DDB) or by a Social Security Administration?

Check “Yes” if, within the past 12 months, the child was in the Katie Beckett Program in Wisconsin, was receiving Supplementary Security Income (SSI) or Social Security related to the child’s disability, in any state, or on a Wisconsin state funded CLTS Waiver. This can be checked “yes” based on parent report.

3.2 Transplant Information

If child has had a transplant, indicate the date completed. If pending one, check the appropriate box. When a parent reports that a child is pending a transplant, the transplant must be imminent in the next 12 months. One way of measuring that is to find out if the child is on the United Network of Organ Sharing (UNOS) list. This does not exclude children who are having autologous (out of self) transplants or have a previously designated donor. However, the list is one useful measure of imminence. A specific plan or timeline for the transplant is another option to establish this criterion. Do not check Pending Transplant if a child may need a transplant following a specific event or for a child who will eventually require a transplant but the time frame is unknown.

List all pending as well as previous transplants that are accurate at the time of the home visit.

3.3 Whose Diagnosis is Accepted?

Screeners are not to interpret people’s complaints or symptoms. If parents report a diagnosis (other than Mental Health Diagnoses – see below), the screener must find out *when* the diagnosis was made and *who* diagnosed the child. If a parent can report that a physician diagnosed the child, the screener can check the diagnosis box. The point is to try to separate the parent’s opinion or suspicion, which shouldn’t be checked for diagnoses, from parent’s report of diagnoses that were made by doctors.

- School records and Birth-to-3 records *do not* count for diagnoses unless the records state that the diagnoses were made by properly qualified professionals e.g., MD or psychologist. The *exception* to this is that Birth-to-3 Program professionals are qualified to make the diagnosis of “Developmental Delay” only.
- A teacher, social worker or therapist diagnosis or suspicion of a specific diagnosis *does not* count for diagnoses for the purposes of the CLTS FS. Even if school personnel have done an Autism rating scale, or the child is qualified for special education services within the Autism category, the screener will not check the diagnosis of Autism on the screen.
- Only check the diagnoses that have been reported to the screener or that the screener sees listed within appropriate documentation. Do not interpret diagnoses from symptoms. For example, if a child has multiple delays in a variety of areas such as learning, mobility,

and self care, do not assume they have a diagnosis of Developmental Delays. Only check the diagnoses for which the screener has verbal report or written record of.

If the screener suspects that a parent is over stating a child's disability, the screener will want to confirm the diagnosis with a qualified professional.

3.4 Child's Diagnoses Must Be Current

Accept any medical/professional diagnosis made within the past year. If a diagnosis was made more than a year ago, confirm that the diagnosis is still accurate for that child and is relevant to the child's needs or condition. If this is the case, then the diagnosis may be entered on the screen even if it was made greater than one year in the past.

There are a **few** diagnoses on the table that are conditions that *may improve*. Cancer, a wound or burn, failure to thrive, even some mental health diagnoses, are examples of conditions that might not really **apply** to a child any more. If a condition has improved such that the child is not on any medications or treatments related to the diagnosis, and no longer has any symptoms from it, then that diagnosis should not be checked on the Diagnoses table.

***Example A:** Ricky is a 15-year-old boy with Muscular Dystrophy. When he was 6 he was successfully treated for Leukemia. He has had no recurrence or symptoms related to Leukemia since then. The screener would not check Cancer on the diagnosis table.*

***Example B:** Sophia is a 5-year-old girl who is doing well and is typical size, weight, and development for her age. As an infant, she was diagnosed with Failure to Thrive, but that was resolved by the time she was 3 years old. A screener would not check Failure to Thrive on the Diagnosis table.*

If a screener is not certain if a diagnosis is still considered current for the child, the screener will need to check with the family or qualified medical professionals.

3.5 Required Documentation of Mental Health Diagnoses

Any diagnosis of a mental health condition, which includes Autism and Autism Spectrum Disorders (such as Asperger Syndrome and Pervasive Developmental Disorder), Substance Abuse, and all other Mental Health Diagnoses require the screener to see written documentation or have verbal confirmation of that diagnosis from a qualified professional (Psychiatrist or Clinical Psychologist). Diagnoses of developmental or physical conditions can be accepted without documentation if the parent can recall when the diagnosis was made and which qualified professional made the diagnosis.

In order to check a Mental Health Diagnosis on the Diagnosis Page, certified screeners must remember to verify the following:

- That a specific mental health diagnosis (NOT a clinical impression or possible diagnosis) was made by a Psychiatrist, Psychologist, Physician or Licensed Clinical Social Worker for whom diagnosing a mental health disorder is appropriate to their specialization and within the scope of their training and practice, AND

- The diagnosis was made through a process using standardized testing, another norm-referenced tool, or through a thorough professional assessment of the child's symptoms.

This verification can be made through written medical record documentation or verbal exchange as long as all requirements are met. This can be accomplished by reviewing clinical assessments or mental health evaluations completed at the time of diagnosis that include not only the diagnosis but also a description of the presenting symptomatology. Recent or current progress notes may also be used that detail the symptoms associated with the verified diagnosis, indicate the symptoms persists, and states the treatment protocols being used to address the symptoms.

Screeners must include information in the note section to support the verification of all mental health diagnoses. In subsequent screens, screeners must be certain the mental health diagnosis and symptoms are still accurate for the child but do not need to verify the diagnosis with the qualified professional on an annual basis.

3.6 Other Diagnostic Considerations

AVOID SYNONYMS FOR CURRENT CONDITIONS

If a child has a condition captured by one of the diagnoses listed on the screen or on the diagnosis cue sheet, check that one diagnosis. Do not include diagnoses that describe another diagnosis already checked for that child's condition.

***Example A:** If a child has "Down syndrome," the screener checks that box. The screener does not have to also check synonyms such as "cognitive disability," "developmental disability," and "genetic/chromosomal disorder."*

***Example B:** If a child has a current diagnosis of Cognitive Disability with a previous diagnosis of Developmental Delays from over a year ago, check only Cognitive Disability on the screen.*

If the screener is not certain that one diagnosis is inherent in another diagnosis, then check both as long as they are considered current diagnoses.

MULTIPLE CONDITIONS/DIAGNOSES

A child may have more than one condition - e.g., Cerebral Palsy and Cancer. In those instances, both Cerebral Palsy and Cancer should be checked. The CLTS FS should accurately capture each *current* diagnosis given to the child. CLTS FS quality assurance procedures will determine if the diagnoses listed for a child are compatible with the needs and supports the child receives.

***Example A:** The screener screens a child with Muscular Dystrophy and the screener also checks in the health-related services section, that the child is getting IV's. A second diagnosis should be present to explain why the child is getting IVs.*

Sometimes a child may have a primary diagnosis as well as secondary diagnoses, again, check all *current* diagnoses. If the screener thinks the primary diagnosis captures the functional limitations that the child has, it is still important to list each diagnoses given to a child.

***Example B:** The screener meets a boy who has a diagnosis of Cognitive Disability and also has Asthma and Allergies. The functional limitations he experiences are directly related to his*

diagnosis of Cognitive Disability. Nevertheless, the screener would check all three diagnoses on the Diagnoses Page.

PENDING DIAGNOSES

In many instances, physicians cannot officially diagnose a child until s/he gets older. In those cases, other Functional Screen questions can determine correct program functional eligibility for the child, and the absence of a diagnosis should not matter. Provisional diagnoses can not be selected on the CLTS FS.

DOWN SYNDROME

There are two listings for Down Syndrome on the Diagnoses Page. One is for Down Syndrome – Mosaic or Translocation and the other is Down Syndrome – Trisomy 21. Generally parents will know which kind of Down Syndrome their child has. Trisomy 21 is the traditional and most common form (95%) of Down Syndrome. In Trisomy 21, the child has an extra chromosome 21 in all cells of their body. Mosaic Down Syndrome indicates that the child has the extra chromosome 21 in some but not all of their cells. Because not all cells contain an extra chromosome 21 the range of physical problems varies depending on the ratio of cells with 46 chromosomes to those with 47 chromosomes. Down Syndrome caused by a translocation of a part of chromosome 21 attaching to another chromosome also varies in severity.

3.7 Diagnoses Cue Sheet

The diagnoses table on the CLTS FS is not all-inclusive; only some of the more common diagnoses or diagnostic categories are listed. Different diagnoses that have a similar meaning are clustered together. For brevity, this table includes the most common and the most “important” diagnoses the screener will encounter. “Important” diagnoses for the Functional Screen means those that are specifically mentioned in state or federal eligibility requirements and others that are needed to establish a specific target group. Some of the diagnoses on the table are required for a child to be eligible. Therefore, accurate diagnoses are very important for the CLTS FS.

The screener will sometimes encounter diagnoses that the screener does not see listed in the table. If the screener does not see a particular diagnosis listed on the table or is uncertain which diagnoses are considered similar, the Diagnoses Cue Sheet will help to guide the screener’s response. The Diagnosis Cue Sheet is accessible via a web-link from the Diagnosis page of the CLTS FS. The Cue Sheet will indicate which box to check on the Functional Screen Diagnosis Table. If the diagnosis is not on the cue sheet, then the screener can check “Mental Health – Other” or “Substance Abuse – Other” box, if appropriate, and write it in. For non-Mental Health or Substance Abuse conditions, enter the diagnosis in the note section on that page. Screeners’ entries will be reviewed periodically to update the Cue Sheet.

If you use the Diagnosis Cue Sheet to determine the proper box to check on the Diagnosis page, write the specific diagnosis the child has in the note section at the bottom of the Diagnosis page.

3.8 Is this a PRESENTING Diagnosis?

For every Diagnosis checked on the CLTS FS, the screener must indicate if it is a PRESENTING Diagnosis. Is the diagnosis checked suspected to be a primary cause for the child to seek long

term support services? Presenting diagnoses are those which focus our efforts. A presenting diagnosis (diagnoses) resulted in the child having needs now, or expected to have needs, that can be addressed through long term support services and will become the direct focus in a service plan for this child. The needs the child has, directly related to their presenting diagnosis (diagnoses) is why a CLTS FS is being completed on behalf of this child.

Example A: *A child has needs related to their diagnosis of Pervasive Developmental Disorder that can be addressed through long term support services, specifically waiver services. The child also has a diagnosis of asthma and/or allergies and/or a facial tic and/or a cleft lip. The PRESENTING Diagnosis for this child is Pervasive Developmental Disorder. The other diagnoses are still indicated on the Diagnosis page but they are not PRESENTING Diagnoses.*

Example B: *A child is applying for long term support services through the Family Support Program because they have home modifications needed for their physical limitations related to a diagnosis of Cerebral Palsy. This child also needs support services due to a Cognitive Disability. In addition, the child has reflux and/or a bedsore and/or delayed puberty and/or hearing loss and/or a neurogenic bladder. The PRESENTING Diagnosis for this child is Cerebral Palsy and Cognitive Disability. The other diagnoses are still indicated on the Diagnosis page but they are not PRESENTING Diagnoses.*

Example C: *A child has Down Syndrome and is applying to a variety of sources for long term support services to help with needs related to their condition. They also have been diagnosed with an ulcer and/or eczema and/or a soft palate deformity and/or torticollis. The PRESENTING Diagnosis for this child is Down Syndrome. The other diagnoses are still indicated on the Diagnosis page but they are not PRESENTING Diagnoses.*

Example D: *A child has severe food allergies resulting in needing a g-tube and needs help with the medical costs associated with this diagnosis. They are applying for long term support services through the Katie Beckett Program due to these allergies. The child also has diagnoses of ADHD and/or low muscle tone and/or a hip dislocation and/or an expressive language disorder. The PRESENTING Diagnosis for this child is Allergy. The other diagnoses are still indicated on the Diagnosis page but they are not PRESENTING Diagnoses.*

All diagnoses a child has are relevant on the CLTS FS. By indicating which diagnoses are “presenting diagnoses” the screen is able to better differentiate the primary concerns a child has that brought them to the point of applying for long term support services. It is expected that a child would have **no more than three** “presenting diagnoses.”

3.9 Primary Care Physician Information

This is a required field. The information does not affect functional eligibility. It may eventually be used for state and local systems changes to improve children’s access to primary health care. These data are also required for federal outcome measurements.

MODULE #4: Mental Health

4.1 Severe Emotional Disorders Diagnoses Summary

This information listed here is pulled directly from the Diagnoses Page. This provides the screener an opportunity to confirm that they have selected the following mental health conditions for the child. The rest of the questions on this page refer to symptoms or needs directly related to these mental health diagnoses.

4.2 Is child currently an adjudicated delinquent?

This question reflects long-standing policy to avoid cost shifting from the Department of Justice to the Family Support Program. If a child is an adjudicated delinquent, then the justice system is responsible for providing whatever assistance the child and family needs, and the child is not eligible for the Family Support Program. This includes youth being tried as adults.

“Adjudicated delinquent” means that a child—currently or within the past year—is or has been under supervision of the juvenile justice system because they violated the law, misbehaved, or posed a threat to others due to their conduct (Chapter 938 of Wisconsin State Statute). This does not include court orders for treatment, or a Child in Need of Protective Services (CHIPS) petition (Chapter 48 of Wisconsin State Statute).

The expanded clarifications below further define the applicability of “adjudicated delinquent” to the Family Support Program:

1. The juvenile has been found as an “adjudicated delinquent” and is currently placed on a dispositional court order. The dispositional court order signed by a Judge means that a Judge determined that there is something the child must actively do, some change in behavior or self correction that will be reviewed at a later date. In addition, services may be ordered for the child whether or not the county system has adequate funding for such services. Services may include assigning a case worker to oversee the court order, as well as more involved services such as treatment, detention, out of home placement, etc.
2. If a child has been given a ticket, charged a fine, required to complete restitution or community service they are not considered an “adjudicated delinquent.” The child may have committed a crime and is under the supervision through a Deferred Prosecution Agreement (DPA), Consent Decree or Juvenile In need of Protective Services (JIPS), but these types of supervision do not meet the threshold of an “adjudicated delinquent.” Even if the child has to return to court at a later date to document that they have not gotten into any further trouble, this does not rise to the definition of “adjudicated delinquent” unless the Judge finds the child violated the agreement and determines the child is now an “adjudicated delinquent.” The Judge will then sign a dispositional court order and item 1 above applies.

If item 1 is true, then the child is an “adjudicated delinquent.” If item 2 is true, then the child is not an “adjudicated delinquent.” When meeting with the family, ask to see documents related to the crime and subsequent decision.

4.3 Duration of Diagnosed Emotional Disability

If the child has a clinical diagnosis of an emotional disability, has the diagnosis, or symptoms related to that diagnosis, persisted for at least six months?

- Yes
- No
- Child does not have an emotional disability

If the child has a clinical diagnosis of an emotional disability, is the disability expected to last a year or longer?

- Yes
- No

Many of the questions on this CLTS FS page reflect current duration requirements for a Psychiatric Level of Care (LOC). Note that the **Autism Spectrum Disorders are Mental Health diagnoses**; the screener may check this box for children with those diagnoses. These include Asperger’s, Autism and Pervasive Developmental Disability. Likewise, ADHD (Attention Deficit Hyperactivity Disorder) and ADD (Attention Deficit Disorder) are Mental Health diagnoses. All of these are diagnoses of an emotional disability and you must answer this question on this page for children with these diagnoses from a qualified professional (MD or Psychologist). Many people identify these diagnoses as developmental in nature. However, they are also considered a clinical mental health diagnosis and you must therefore answer this question accurately. Answering this question correctly will increase the likelihood of an appropriate functional eligibility determination for these children.

Regardless of the answer to these questions, complete the Mental Health section for every child who has a mental health diagnoses. In addition, if a child does not have a mental health diagnosis but is exhibiting mental health symptoms or receiving mental health services, the screener can indicate that on this page. Every question on this page relate directly to mental health issues or concerns.

4.4 Mental Health Symptoms/Minimum Frequency

The minimal frequency of mental health and behavioral symptoms is lower than the criterion used for ADLs and IADLs. For the mental health symptoms, the screener should check the box if:

- Child currently has symptoms as defined, or
- Child had the symptoms as defined within the past three months, or
- Child had the symptoms as defined at least twice in the past year.

Does child have any of the following symptoms? (Check all that apply and enter notes below)

- Anorexia/ Bulimia - Life-threatening syptomology.

- Psychosis - Serious mental illness with delusions and/or hallucinations.
- Suicidality - Suicide attempt in past three months or significant suicidal ideation or plan in past month.
- Violence - Life-threatening acts.

For Anorexia/Bulimia – Life-threatening Syptomology the effects of the eating disorders must include at least one of the following:

- Malnutrition diagnosed by a physician.
- Electrolyte imbalances diagnosed by a physician. Electrolytes are body salts like sodium, potassium and chloride.
- Body weight or development below 20th percentile due to the eating disorder as determined by a physician.

For Anorexia/Bulimia and Psychosis, there should be a corresponding diagnosis in the Diagnosis table of the CLTS FS.

Psychosis occurs only with severe mental conditions resulting in loss of contact with reality through delusions or hallucinations. A delusion is defined to be a belief that is pathological (the result of an illness or illness process) and is held despite evidence to the contrary. A hallucination, in the broadest sense of the word, is a perception in the absence of a stimulus. Hallucinations can occur in any sensory modality — visual, auditory, olfactory, tactile, and many others.

Violence is defined as life-threatening acts that endanger another person’s life. This life-threatening act **must** result in one of the following:

- Cause other person to require hospitalization (does not include an ER visit).
- Use of weapons against someone (e.g., gun, knife, chains, switch blade).
- Arson (purposeful fire setting) or bomb threats.

If the behavior does not meet this requirement, the screener may be able to check one of the behaviors listed under the category: Aggressive or Offensive Behaviors on the Behavior Page of the CLTS FS.

4.5 Mental Health Services

Does child currently *require* services from any of the following? (Check all that apply)

- **Child Protective Services**
- **Clinical Case Management and Service Coordination across Systems**, this is case management or service coordination specifically for services rendered through the mental health system.
- **Criminal Justice System**, this includes Juvenile and Adult Justice Systems.

- **Mental Health Services:**
 - Psychotherapy specific to the child’s diagnosis, including day treatment programs.
 - In-home therapies for children with Autism, Asperger Disorder or Pervasive Developmental Disorder.
 - If a child is participating in on-going in-home therapies once they have completed the intensive program then these therapies are only listed as Mental Health Services if the specific therapy is overseen by a psychiatrist or psychologist.
 - Mental Health Services does not include psychiatric medications; however, this does include psychiatric visits on a regular basis for the prescription of those medications.
 - This excludes treatment for substance abuse only, which is captured below.

- **Substance Abuse Services**, this includes day treatment and outpatient services.

- **In-school Supports for *Emotional and/or Behavioral Problems***
 “In-school supports” includes special education classes, one-on-one assistance, or a Behavioral Intervention Plan (BIP) in an Individualized Educational Plan (IEP). This is for emotional or behavioral problems; do not check it for children with only cognitive and/or physical disabilities.

This item is checked in the following situations:

1. Child has an Individualized Educational Plan (IEP) for Emotional/Behavioral Disorders (EBD) programming. This is not applicable if the support is only for issues related to focusing, staying on task or organization.
2. Child has an active Behavioral Intervention Plan (BIP) in an Individualized Educational Plan (IEP).

Sometimes children have behavioral plans that are essentially inactive because the child has not had the behavioral problems for a long time. If the child is not in special education classes and does not have one-on-one assistance, check this item only if the behavioral plan has actually been used. In this situation, check the box if interventions are needed **at least three times per week**. “**Interventions**” here means a school staff must verbally and/or physically provide or assist the child with behavioral controls. The staff person may have to interrupt or prevent the behavior, remove the child from the situation, or respond in ways to help the child cope and avoid harm. This does not include children who need to have someone help them to stay focused, stay on task or assistance to maintain organization in the classroom.

Some children will have an item in their IEP that states that their behavior impedes his/her learning and/or the learning of others. This, by itself, is not enough evidence to select In School Supports for this child.

“Require” is based on the qualified, treating professional’s recommendation that a specific service is essential to address the child’s identified mental health need. The professional recommendation must be made within the past year. It cannot be solely based on parental desire for services. Most children who require these services will be receiving them, but on occasion a parent or child cannot, or will not, participate in recommended services or the recommended

services are not available. If the parent or child has refused to access recommended services for over 12 months, then this recommendation is considered no longer valid.

4.6 Rare and Extreme Conditions

These three conditions are rare and extreme and usually don't cause physical harm to the child or others. They are directly associated with mental health disorders and the child's ability to function throughout their day, every day, all day and night. They are usually not considered overt behaviors and are often better described as a lack of behavior or action. There are limited interventions because the condition appears to be a direct result of their mental health status. They are a measure of the severity of a child's mental health condition. Consideration needs to be given to these rare and extreme conditions as the severity of these circumstances is significant. The following three questions address these unique situations.

Does this child exhibit disruptive behaviors in structured settings on a daily basis that require redirection from an adult at a frequency of every 3 minutes or more often **AND** this behavior has been demonstrated consistently for the past 6 months (do not count summer months)? Disruptive behaviors may include sliding around a room in a chair, screaming out inappropriate words or phrases, sitting in the center of a room and refusing to move.

- Yes
- No

This question will only be answered in the affirmative in extremely rare situations. It is imperative that the screener confirm that the frequency of this disruptive behavior occurs "every 3 minutes or more often" all day, every day. The redirection must be for a disruptive behavior not simply lack of focus or off task behaviors. The disruptive behavior must be a direct result of their mental health condition. If a child has been removed from the regular classroom due to this behavior, check "no" unless they exhibit disruptive behaviors of this same intense frequency in alternative classrooms or school settings as well.

Does this child experience nightmares or night terrors at least 4 times a week **AND** this sleep interruption has been consistent for the past 6 months? These nightmares or night terrors must be characterized by repeated frightening episodes of intense anxiety that may be accompanied by screaming, crying, confusion, agitation, and/or disorientation.

- Yes
- No

All children may have nightmares or even the occasional night terror. This question is intended for the child who has these intense experiences at least 4 nights a week, for months. If the condition does not meet this frequency, then check "no" and describe the situation in the note section.

Is this child unable to complete routine events (hygiene tasks, leaving the house, walking on certain pavements, or sharing community equipment with others) throughout the day, every day, consistently for the past 6 months due to an obsession? An obsession is a thought, a fear, an idea, an image, or words that a child cannot get out of his/her mind. It does not include self stimulating or compulsive behaviors. The child experiencing the

obsession must be aware of the obsession but not be able to control the influence of his/her own thought patterns.

Yes

No

In general, this question will be most appropriately answered in the affirmative if the child has a diagnosis of a severe Obsessive Compulsive Disorder or a severe Anxiety Disorder. Again, this is only going to be answered “yes” in rare and extreme cases. This does not apply to a child with sensory needs that cause them to engage in repetitive behaviors. Keep in mind that the question indicates that the child must be aware of the obsession but not be able to control the influence of their own thought pattern. They would be able to express their awareness of their own behavior and their desire to stop this behavior but an inability to do so due to their mental health condition.

MODULE #5: Behaviors

5.1 Overview of Behaviors

This section serves two purposes:

1. To allow screener to describe behavioral symptoms in any child, and
2. To present existing criteria for functional eligibility for the Mental Health target group.

“Behaviors” is a separate section from “Mental Health” on the CLTS FS. Screeners may check behavior boxes for children who do not have emotional disability or mental health symptoms. The Behavior section allows the screener to describe behavior problems that result from cognitive, emotional or social impairments.

5.2 Definition of Behaviors

The behaviors listed are precisely defined to increase inter-rater reliability. Please follow the definitions precisely and contact designated State Clinical Staff with questions.

HIGH-RISK BEHAVIORS

1. Running Away

Impulsive flight to unsafe locations with the intention of not returning. These are children who will be living on the street if intervention is not provided.

Examples for children under 6 years old:

This behavior **is** checked for children who:

- Run off in a store and leave the building without notice.
- Run away in their home neighborhood and cannot be found with reasonable effort.

This behavior **is not** checked for children who:

- Run off to a known location, such as their favorite play structure in a neighborhood park or a friends’ house.
- Bolt away from their parent/caregiver but stay within a reasonable distance (e.g., runs from the back yard to the front yard).
- Wander off without supervision.

2. Substance Abuse

Use of illegal drugs including alcohol or misuse of prescription medications. This does not include use of tobacco products.

3. Dangerous Sexual Contact

A child who is a victim of sexual behavior (intercourse, oral sex, or other genital contact) even if the child willingly engages in the activity. This includes contact with sexual partners from the internet (i.e., face to face or by webcam), having substantially older sexual partners or having sex with strangers.

4. Use of Inhalants

Inhalants are substances that can be inhaled from an aerosol can, a cloth or cotton ball that is soaked with an inhalant, a plastic bag, or balloon, and will cause a mind-altering effect within 2-5 minutes after inhaling.

Commonly used inhalants: Correcting fluid, degreasers, paint remover, paint thinner, aerosol deodorant, aerosol fabric spray, aerosol hair spray, aerosol cooking spray, aerosol cleaning products, whipping cream containers that contain nitrous, spray paint, nail polish remover. Less commonly used inhalants: felt tip markers, gasoline, dry cleaning fluid, and glue

Important note: Inhalants can cause damage to all organs, including the brain, but the damage can be reversible if the use of inhalants stops after a short period of time (within a few months). If the inhalant use is not stopped within that time period, then the damage to the organs is irreversible and the child will face significant medical and psychological impairment that will last a lifetime.

SELF-INJURIOUS BEHAVIORS

1. Head-banging

Repeatedly banging one's head against hard surfaces. This does not include children who bang their heads due to sensory integration or visual/hearing impairments. This does not include children who hit their own head with their open hand or fist.

2. Cutting or Burning or Strangulating Oneself

Repetitive cutting open the skin with a sharp object like a knife or razor, or repetitive burning one's skin with a lighter, candle, or stove. Excessive piercing or tattooing is not self-injury if the primary purpose is body decoration or to fit in with peers. Non-lethal strangulation involves the production of unconsciousness or near unconsciousness by restriction of the supply of oxygenated blood to the brain: the act of suffocating by constricting the windpipe.

3. Biting Oneself Severely

A severe form of self-mutilation that can lead to: the loss of lips and fingers from biting. A child that engages in this behavior will attempt to rupture the skin, may bleed, and will most likely scar. A child that bites their nails or cuticles because of a nervous habit would not be considered a child that self-mutilates.

4. Tearing At or Out Body Parts

A severe form of self-mutilation which can lead to vision loss from rubbing the eyes, tearing their nose and ears, and any number of other severe injuries. A child that picks at a scab or scratches until a body part bleeds would not be considered a child that self-mutilates. It also does not include hair pulling. Severe hair pulling, for which the child is diagnosed with Trichotillomania is captured on the diagnosis page.

Reasons for Self-Injurious behaviors:

- Rapidly reduce the tension in their body and mind.
- Relieve their emotional pain caused by feeling worthless, angry, fearful, abandoned, depressed, anxious, or trapped.

- Feel pain that tells them they are "alive" thus warding off emotional detachment.
- Regain control since turning mental and emotional pain into physical pain is easier for them to handle.
- Punish themselves for real or perceived offenses like being bad, fat, ugly, stupid, or guilty.
- Express anger/rage when words or outward actions are unacceptable or when the pain is too severe to put into words.

5. Inserting Harmful Objects into Body Orifices

Harmful objects include anything that can puncture the skin such as scissors, knives, pens and pencils. Other objects that cannot cut, tear or puncture the skin such as food, paper products, cotton balls coins and fingers should not be considered when answering this question. Inserting harmful objects is only considered a form of self mutilation when done with such force that puncturing their skin is likely. Therefore, simply putting an item in an orifice is not considered self mutilation unless there is the intention to cause physical harm.

AGGRESSIVE or OFFENSIVE BEHAVIOR TOWARD OTHERS

1. Verbal Abuse

To be considered abusive, words **must**:

- a) Be presented in a threatening, harassing, or violent manner, AND
- b) Be reasonably expected to cause physical, sexual, or mental harm.

This is not to be checked for children who yell, scream, shout or use profanity or other foul language unless the above requirements are met. It is a rare child who rises to this level of verbal attack. A measurement of harm is whether the abuse is of such severity that *the target of the verbal assault requires professional intervention to address the physical, sexual or mental harm.*

Do not duplicate with Serious Threats of Violence. If violence is expected, check Serious Threats of Violence rather than Verbal Abuse. "Bullying" is considered only if it meets criteria "a" and "b" above.

2. Hitting, Biting, or Kicking

Expression of anger through these behaviors **beyond** an age appropriate level. Must involve a pattern of aggressive behaviors rather than a single incident. May be a result of a rage reaction in older children but should not be counted when included in a temper tantrum in young children. Note: rage is characterized by an unpredictable and primitive display of violence that is out of proportion to the provoking event and often threatens serious self-injury or harm to others. Hitting, biting, and kicking are not considered an aggressive behavior if a child is reacting in the moment to frustration from a communication/language disorder.

3. Masturbating In Public

Masturbation is not abnormal or excessive unless it is deliberately done in public places after age five or six, when most children learn discretion and masturbate only in private.

4. Urinating on Another or Smearing Feces

Urinating on another is understood as literally urinating on another person. This does not include accidental urination during normal elimination in a bathroom or on a changing table. This does not include urinating in inappropriate places such as public parks, etc. It only applies to children who urinate directly on another person. Smearing feces involves intentional spreading of feces onto inappropriate places such as on the floor/walls/furniture.

5. Serious Threats of Violence

Threats about hurting or killing someone or a group of people. This doesn't include suicidal threats as that is covered on the Mental Health page. This involves a sequence of overt, serious, hostile behaviors or threats directed at peers, teachers, parents or other individuals. This is not to be mistaken with the child who expresses their anger at having too much homework by saying in the cafeteria over lunch, "I hate school, and I want to kill my teacher." The threats must be perceived by anyone who witnesses them as true threats of violence.

6. Sexually Inappropriate Behavior Toward Children or Adults

This behavior is a prominent motivation in a child's life when interacting with others. It includes when sexual play or behaviors are not welcomed by others, including inappropriate sexual comments or gestures, mutual sexual activity with other children, or sexual molestation and abuse of other children or adults. Examples are: aggressive attempts to undress, sexually touch, or attempt intercourse.

7. Abuse or Torture of Animals

Abusing animals to find power/joy/fulfillment through the torture of victims they know cannot defend themselves. This includes abusing animals for no obvious reason. For purposes of the CLTS FS, the child must be demonstrating this behavior with multiple animals, not just the household pet. Note: nearly all children go through a stage of "innocent" cruelty during which they may harm insects or other small animals in the process of exploring their world. Most children, however, with guidance from parents and teachers, develop empathy for the pain animals can suffer.

LACK OF BEHAVIORAL CONTROLS

1. Destruction of Property / Vandalism

Destruction of Property involves destroying the property of others by means other than fire setting. The intentional destruction of property is popularly referred to as vandalism. It includes behavior such as breaking windows, slashing tires, spray painting a wall with graffiti, and destroying a computer system through the use of a computer virus. Vandalism is a malicious act and may reflect personal ill will, although the perpetrators need not know their victim to commit vandalism.

2. Stealing, Burglary or Kleptomania within the Community

- *Stealing* means taking the property of another without right or permission. For the purposes of the CLTS FS, it does not include taking property from the child's own home as it must occur within the community.
- *Burglary* is the unlawful entry into a building or other structure with the intent to commit an illegal act.

- *Kleptomania* is a condition in which a person is compelled to steal things, generally things of little or no value, such as pens, decorative pins, or wall decorations. They are often unaware of performing the theft until some time later.

3. Other (list)

Not only does the child for whom this answer would be filled in and selected have to demonstrate this listed very atypical behavior, but that behavior also must be so extreme that it affects the child's ability to be in a variety of settings because it causes serious problems for others around them. In summary, this option is reserved for a behavior that meets ALL of the following characteristics:

- Cannot be captured in any of the other behavior options,
- Occurs in a variety of settings (home, school and community), AND
- Causes extreme distress/disruption to others.

5.3 Frequency of Behavior

When answering this question, consider the behavior each month over the past 6 months. Frequency is measured in days rather than episodes.

- Never
- Less than once a month
- 1-3 days each month
- 1-3 days each week
- 4 or more days each week

If the behavior was present within the past 6 months but no longer occurs, indicate frequency as "Never."

Example A: The screener meets a child who was engaging in self injurious behaviors as recently as 5 months ago but was put on medications and has not engaged in that behavior since. The screener would not select a frequency (other than Never) for this behavior.

If the behavior is new, indicate the current frequency of the behavior.

Example B: The screener meets a child who ran away from home for the first time 2 weeks ago, and there was no indication that this behavior was a one time episode. The screener would check "Less than once a month" for this behavior.

Example C: The screener meets a child who starting cutting their arm three weeks ago. The child is engaging in this behavior at least 2-3 days a week. The screener would check "1-3 days each week."

If the behavior fluctuates on a predictable basis, indicate the predictable frequency of the behavior.

Example D: The screener meets a child who always has difficulty with aggression towards others on a cycle of one to two weeks every month. During these weeks, the child will be severely aggressive with hitting, kicking and biting others on a daily basis. Then the behavior

stops but always returns the next month for a week or two. The screener would check “4 or more days each week.”

If the behavior fluctuates and is not predictable, then consider it more “episodic” and select “Less than once a month.”

***Example E:** The screener meets a child who will bang their head severely but there is no pattern to this behavior. In the past 6 months the child engaged in this behavior 2 days the first month, not at all the second or third month, 8 days the fourth month, not at all the fifth month and just banged their head twice in the last week. The screener would check “Less than once a month.”*

5.4 Current Intervention Category

Select the category that is most often used to address the child’s behavior. Consider any intervention listed under the category, the current intervention does not need to include all the listed interventions. Use the Intervention Category that is most often used with the specific behavior, even if the behavior is not under control at this time. If multiple interventions are used that represent different intervention categories, select the most extreme intervention that **has been** used in the past 6 months and **may be used** in the future. If caregivers do not intervene, ignore the behavior, or only use occasional time outs, check “None” for intervention.

TIME OUT / SUPERVISION

- Regular time-outs**
- Restricted community access**
- Constant supervision (“in-line of sight”)**

Regular time-outs: Child requires frequent breaks from activities in order to regain a state of calm behavior. This does not include use of grounding or removing privileges as punishment for a behavior. This does include a child on an in-school suspension.

Restricted community access: A specific treatment or intervention decision has been made to restrict this child’s access to the community to prevent harm to themselves or others. The restricted access must involve multiple community locations. It may include out of school suspensions as long as it is in conjunction with other community restrictions.

Constant supervision (“in-line of sight”): Child needs constant supervision by one or more adults. This is regular supervision throughout the day. This child does not need someone within an arm’s distance but does need someone within the same room to provide supervision for safety.

MEDICAL / PROFESSIONAL TREATMENT

- Professional medical treatment**
- Regular professional therapeutic treatment**
- Regular use of protective gear**
- Environmental restraints**
- Constant supervision (“within arm’s reach”)**
- Does not include having a medication prescribed to address behavioral issues
- Does not include proactive strategies to help prevent behavioral issues

Professional medical treatment: Child’s behavior results in injury to themselves or others such that the injured person needs medical attention at a clinic or hospital. This is not the child who causes injuries that can be mended using traditional first aide (for example, Band-Aids for cuts or ice for bruises).

Regular professional therapeutic treatment: Child’s behavior is addressed through consistent behavioral or psychotherapeutic intervention with a psychiatrist, licensed psychologist, clinical social worker or marriage and family therapist. Child benefits from an implemented therapeutic plan developed with professional oversight. This does not include monitoring or administration of a medication regime.

Regular use of protective gear: Child must wear protective gear to avoid injury to themselves or others.

Environmental restraints: Child needs to have exterior doors of their home double locked, have specialized locks on windows, and/or the use of door alarms to ensure their safety or the safety of others.

Constant supervision (“within arm’s reach”): Child’s behaviors require that others be able to quickly physically intervene to assure physical safety.

EMERGENCY

- Urgent or emergency medical treatment**
- Police involvement**

Urgent or emergency medical treatment: Child’s behavior resulted in an individual requiring immediate medical intervention or necessitated calling an ambulance. This could be the result of self injurious behaviors. Remember that violent acts that result in inpatient care for the victim are covered on the Mental Health page under Violence.

Police involvement: Child’s individual behavior has resulted in a call to the police and they arrive on site. It does not matter if charges were filed; the fact that police were involved is enough.

5.5 Duration of Behavior

Expected to last 6 months or longer?

If the behavior is chronic, then check “yes” to this question. If the screener is uncertain, check “yes” to give the child the benefit of the doubt for the next year but be certain to review again at time of re-screen.

5.6 Behavior in Multiple Locations

Due to the nature of a number of defined behaviors, some behaviors must occur in multiple locations in order to be selected on the CLTS FS. The only exception to this requirement is

made when a child lives in one environment at all times (e.g., a young child who is cared for entirely at home). This chart guides screeners to know when to consider whether or not a particular behavior occurs in more than one setting.

BEHAVIOR	MULTIPLE LOCATIONS?
High-Risk Behaviors	
Running Away	No
Substance Abuse	No
Dangerous Sexual Contact	No
Use of Inhalants	No
Self-Injurious Behaviors	
Head-Banging	Yes
Cutting or Burning or Strangulating Oneself	No
Biting Oneself Severely	No
Tearing at or Out Body Parts	No
Inserting Harmful Objects into Body Orifices	No
Aggressive or Offensive Behavior Toward Others	
Verbal Abuse	Yes
Hitting, Biting, Kicking	Yes
Masturbating in Public	No
Urinating on Another or Smearing Feces	No
Serious Threats of Violence	No
Sexually Inappropriate Behavior Toward Children or Adults	No
Abuse or Torture of Animals	No
Lack of Behavioral Controls	
Destruction of Property / Vandalism	Yes
Stealing, Burglary or Kleptomania within the Community	Yes

5.7 Unable to Describe Child

There may well be many behaviors that children demonstrate that will not be reflected in the questions asked on the CLTS FS. As with ADL/IADL questions, the CLTS FS is set up to capture items that will affect functional eligibility and that is why behaviors need to be of a more extreme nature. If the screener wishes to document behaviors not reflected in the very specific CLTS FS questions, those behaviors can be described in the Notes section.

5.8 Current Interventions Have Extinguished the Child's Behavior

If the child exhibited behaviors and then started some type of physical/therapeutic intervention to address those specific behaviors, the screener needs to consider whether those behaviors could resurface if the physical/therapeutic interventions are removed. Types of physical/therapeutic intervention may include:

- In Home Therapy for children with Autism
- Day Treatment
- Treatment foster homes

If the professionals involved agree that the child's behaviors would resurface if the interventions were discontinued, then the screener is directed to check the behavior/frequency/intervention of the specific behavior prior to receiving the intervention. In addition, the screener must select that the behavior is expected to last 6 months or longer. *Do not* try to predict what the behavior would be in the future; simply rely on the information available prior to treatment.

In this context, physical/therapeutic interventions do not include medications. If a child is on a medication and is no longer exhibiting a specific behavior or the level of frequency has changed as a result of the medication, then only check what is currently (within the past 6 months) true for the child.

This option does not apply in situations where the child has been removed from their family's home due to issues related to family dynamics. If the child's behaviors are specific to their family of origin but are not exhibited in other homes, this option does not apply. This is an example of a circumstance that requires the support of the foster care system rather than children's long term support programs.

MODULE #6: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

6.1 Overview of ADLs/IADLs

The computer application of the CLTS FS will calculate the child's age and present only the ADL/IADL answer choices appropriate for the child's age. Although the screener should not use the full paper screen in a home visit, the screener may wish to take along a print-out of the ADL/IADL answer choices that match the child's age, and refer to it as needed. The screener can print this from the "Forms" link in the CLTS FS application.

These answer choices were developed by the screen workgroup using well-established child development guidelines. Modifications were made in order to meet our screen development goals:

- Accuracy (match current functional eligibility rules and clinical judgment)
- Brevity (unnecessary information was left out)
- Objectivity/ inter-rater reliability (i.e., reduce subjectivity as much as possible)
- Inclusiveness (able to describe various needs of children)

These four criteria can obviously conflict. The balancing between these goals is especially evident in the ADLs.

The wording of each answer choice was crafted to be as precise and objective as possible to promote **inter-rater reliability**. This can obviously be challenging when trying to be **inclusive** of all children with or without physical, cognitive, or emotional disabilities.

Similarly, **brevity** can conflict with inclusiveness and accuracy, since children's abilities must be broken down by age groupings. If functional eligibility is not affected, brevity is chosen over inclusiveness. Since **age-appropriate** needs are not "necessary" information (they don't help with determining program eligibilities) they are not included among the ADL/IADL answer choices. This means that screeners **will not be able to describe every child's needs**, if the needs are "age-appropriate," i.e., similar to those of non-disabled children of the same age group. ("Similar" here means the same as, or **too difficult to distinguish** without subjectivity and excessive length of the CLTS FS)

Age-appropriate descriptions (such as complete cares for infants) were left off the CLTS FS for brevity. Babies are properly determined eligible even without checkmarks on some of the ADLs/IADLs.

6.2 ADL/IADL Requires Substantial Impairment AND Frequent Assistance

A substantial functional impairment is a restriction on the child's ability to engage in age appropriate everyday activities or perform daily functions. The ADL/IADL questions on the screen are designed to capture substantial impairments based on the child's age. The child must need hands on adult assistance to complete these functions across settings including home,

school and community. The hands on help is not offered simply to complete the task quicker, or make the task easier, but is provided as a necessity to complete the task on a daily basis.

FREQUENCY is a critical aspect of the substantial impairment requirement. ADL/IADL questions are to be checked only if the child needs help from an adult in order to complete the activity of daily living, as defined by the functional screen questions, on a regular basis. If the child needs infrequent assistance to complete the task, it cannot count toward functional eligibility for long-term support programs. Therefore, if the child completes the task most of the time on his/her own and only occasionally needs help from an adult, the box for that question is not checked. In many cases, a child's need for help is quite consistent: "She can't do that," or "He always needs help with this," or "Most of the time..." In these instances, the tasks should be checked. In addition, if the child has been able to complete the specific task(s) on a rare or infrequent occasion, which means the child is considered unable to complete the task on a regular basis and the box is checked. If the child needs assistance most of the time, then the box is checked.

In general, screeners should consider whether or not the need for help is some of the time versus most of the time. If the child needs assistance from others most of the time, then it counts as a checked box on the CLTS FS – that indicates that the child's limitation is substantial. If the child needs assistance only some of the time, the ADL/IADL answer choice should not be checked – that indicates that the child's development is within the range of typical development for a child of a comparable age, and not consistent enough to be categorized as a substantial impairment.

The substantial impairment, as described in the question on the screen, must relate to the day in/day out routine of the child. If the family is providing hands on support to the child for a skill even though the child can do the task independently, then **do not** check the box. If a parent says, "now and then," "every few weeks," or "a few times, not mostly," the frequency is probably only some of the time and therefore the child would not meet the required level of frequency needed to check the box. One way a screener can obtain clearer information is to ask the parent "In the past few months, would you say he's needed help most of the time?" In general, consider ADL/IADL function over a six-month timeframe, unless the child has **new needs** or has developed **new skills**.

It is not expected that the screener test the child or measure her needs or abilities during a home visit. A child's needs cannot be determined from a single episode but must reflect the child's typical or average functional need over the past six months. This is particularly important when reviewing documentation about a child's abilities. A report that indicates that a child completed a specific task may not represent the typical needs of that child. Be certain to verify any statement or assessment of frequency with various care providers who know the child well.

***Example A:** Juan has cancer and gets very sick during chemotherapy and he needs help with his ADLs then; at other times he is independent with them. Juan gets chemotherapy one week each month. Screener does **not** indicate that Juan needs help with his ADLs because he needs help only some of the time – one week out of four.*

***Example B:** Tia was potty-trained two months ago and is doing well with it. Screener does **not** check box for needs help with toileting (although she did, four out of the past six months), because Tia has developed this skill and now rarely needs any help.*

6.3 Child Functions within Normal Limits

On all Activities of Daily Living and Instrumental Activities of Daily Living, screeners must determine if the child functions within normal limits prior to selecting any specific item(s) under a category (e.g., Bathing, Dressing, Communication, or Social Competency). If indeed a child functions within normal limits for that particular ADL or IADL, then “None of the Above Apply” must be selected for that child. A screener can support this selection by writing a note that explains that the child does not have substantial functional impairments in that particular skill area. The specific items available on the CLTS FS are only to be selected once it has been determined that a child does not function within normal limits.

***Example A:** Jeffrey does not receive Speech Therapy at school, his parents do not express any concerns about his ability to communicate and during the home visit the screener is able to have a conversation with Jeffrey. In this circumstance, “None of the Above Apply” would be selected under Communication on the IADL page without any further review of the particular options under Communication.*

***Example B:** It is reported that Savanna bathes herself and that no other person is in the bathroom during this task. There is no need to ask any further questions for Bathing on the ADL page. “None of the Above Apply” is selected.*

***Example C:** Emily is a very social child. She has friends and is able to advocate for her own needs. She is not involved in any social skills classes at school. Her social skills are within normal limits. “None of the Above Apply” is selected under Social Competency on the IADL page and no additional specific questions about Social Competency are asked.*

6.4 "Needs" versus "Safety"/ Fluctuating Needs

“Needs” and “safety” should not be over-interpreted or over-used to express screeners’ subjective opinions. The CLTS FS is intended to be an objective screen of children’s need for assistance. Thus, the screener should ask, “Would another screener of another discipline rank the child the same way?”

It is often difficult to distinguish a child’s needs from parents’ preferences. Sometimes parents may prefer to perform or help with tasks even though the child could do them. If a child can complete a task independently, but it takes them a long time, the screener needs to consider whether or not the child "needs any help to complete the task." Sometimes it takes a child so long that the parent must do the task so that the child gets to school on time. This is not just for convenience, and amounts to most of the time (since its five days out of seven); it would be counted as help needed on the Functional Screen. This only applies to situations where the family members are providing physical assistance to get the task completed.

The screener will quite often encounter different versions of the child’s abilities from different parties. This is discussed in the first part of the instructions. Also, there are instructions for how to deal with fluctuating needs, and with the fact that a child may function differently, e.g., at

home and at school. Please review those earlier sections as needed under 1.8 Screening Limitations (page 11).

6.5 Step by Step Cueing versus Reminders and Encouragement

Many ADL questions will ask whether the child requires “Step by Step Cueing”. This represents a need for another person to be present while the child completes the task to verbally cue the child for each step throughout the task. For example, put the toothpaste on the brush, put the brush in your mouth, brush these teeth, now these teeth, put the toothbrush down, rinse and spit. It does not apply to children who need to be told repeatedly to brush their teeth or take a shower. It does not apply to children who have to be sent back in to shower again because they missed a spot or didn’t rinse enough. It does not apply to children who use a visual reminder of the steps of the process, like a chart or list. It literally means step by step verbal instruction.

6.6 Corroborating Activities of Daily Living Between Home and Other Environments

It is imperative that screeners examine the child’s abilities and limitations in multiple environments. Some of the questions on the ADL page, especially those regarding Grooming, Dressing, Toileting, Mobility and Eating, must be evaluated in multiple environments. Questions about Bathing are more limited to the child’s home environment and perhaps the parents are the only resource for this information. For the other Activities of Daily Living and Instrumental Activities of Daily Living, it is not enough to ask a child’s parents about their functional abilities in these areas, it is also essential that screeners find out how the child functions throughout their day, in different environments. For very young children, their home may be the only environment in a day but for many children they also attend early childhood, day care environments or various school programs. For older children, they may be able to directly describe their ability to care for themselves in these different environments.

Examples:

- *Are they able to use the bathroom independently at school?*
- *Can they eat independently in other places?*
- *Do they need help washing their hands and face when outside their family’s home?*
- *Do they communicate effectively in the community?*

There are many reasons why these skills need to be evaluated in multiple environments. At times the parent-child dynamic can blur the true need as described above in “Needs” versus “Safety”/ Fluctuating Needs. In addition, the screen is to capture the child’s ability most of the time. To neglect to gather information about a child’s ability to complete ADLs and IADLs outside of the home results in an incomplete picture and therefore, an incomplete screen. To truly reflect the level of limitation a child has and the type of support they require throughout their day, information about Activities of Daily Living and Instrumental Activities of Daily Living must be gathered and corroborated by multiple sources.

6.7 Communication and Learning Assessments

All assessments listed for Communication and Learning are Standardized Norm-Referenced tests that specifically measure Expressive Communication, Receptive Communication or Cognition. A norm-referenced assessment is designed such that a child's performance is compared to a larger group. Usually the larger group or 'norm sample' is a national sample representing a wide and diverse cross-section of children. The result is a bell curve based on that normative sample. The normative sample also determines for which age group these assessments and results can be used. In contrast, criterion-referenced assessments measure how well a student performs against an objective or criterion rather than another student.

Valid Results

The results of any assessment **must** be considered VALID. The only scores that should be considered when answering this question are assessment results in which the evaluator is confident in the accuracy of the test results. There are many circumstances in which the test results are not accurate and therefore not useable. For example:

- If the results are listed with qualifiers such as “child was unable to focus on the tasks of the tests” or “child’s behaviors’ interfered with accurate test results” or any other indication that the results may not be a true reflection of the child’s abilities.
- If the child was considered “un-testable” do not assume that they would meet a 30% delay or 2 standard deviations below the mean.
- If the child being tested was of a different age than the range that is measured by a particular tool, do not consider those results to be an accurate reflection of the child’s abilities.
- If the test was not administered in full or within the allotted time limit.

Make special note of the number of months/years associated with each question (it varies based on the age of the child).

In order to document a valid assessment on the CLTS FS, the following information must be available:

- Assessment date (mm/yyyy)
- Name of the Assessment Tool
- Valid Results of the Assessment
 - Within Normal Limits
 - A Percent Delay (greater than, less than or equal to the required delay for purposes of functional eligibility)
 - A Standard Deviation below the norm (greater than, less than or equal to the required delay for purposes of functional eligibility)

Knowing the child's percentile is not the same as their percent delay and is not relevant for the purpose of the CLTS FS.

Interpreting Test Results – Standard Deviations

Interpreting test results is often difficult. Most tests are based on a normative score of 100 with a standard deviation of 15. That means normal results are within 15 points of 100; or between 85-115. To get this average, one standard deviation is subtracted from the norm and one standard deviation is added to the norm ($100-15 = 85$ and $100+15 = 115$). Low normal or borderline

scores fall between 70-85 which is 1-2 standard deviations below the norm. If one standard deviation is 15 points, then two standard deviations is 30 points. Assuming that 100 is the norm, 2 standard deviations below the norm would be a score of 70 or below. All scores between 70 and 130 are considered within normal limits. Many test results do not report a final score that fits into the category of standard deviations. One option is to contact the professional who administered the test. In the case of communication assessments, any speech pathologist may be able to help accurately interpret the results. In the case of cognitive assessments, any psychologist may be able to help accurately interpret the results.

Some norm referenced tests results indicate scores in the single digits, like 1 or 3. Without knowing the norm score and the standard deviation score, these are very challenging to interpret. Again, consulting with the administrator of the assessment or another qualified professional may be the best method to interpret this data.

Interpreting Test Results – Percent Delay

The most important meaning to be aware of when talking about percentages is to understand the clear distinction between percent delay and the term “percentile”. Percentile is often listed in the results of a norm referenced assessment. It represents where the child’s score ranks against all scores from other children who have taken that same assessment. By definition, a percentile rank is the proportion of scores in a distribution that a specific score is greater than or equal to. For instance, if a student received a score of 95 percent on a math test (by getting 95 out of 100 questions correct) and this score was greater than or equal to the scores of 88% of the students taking the test, then the percentile rank would be 88. The student would be in the 88th percentile. Clearly percentile does not address what percentage of a delay the student has in math. In this example, the student would have a 5% delay with a percentile of 88.

In general, assessments of children with communication or learning delays result in percentile scores that are often much lower, like the first or second percentile. Although this sounds like a substantial delay, it does not directly translate to how delayed their skills are.

A percent delay measures how far behind the child’s results are to other children their age. This is evident in Age Equivalent (AE) scores. If a 12 year old child took a norm reference test and had a valid result with an age equivalence score of 6;6 (years; months), for example, they would be more than 30% delayed. In fact, they are demonstrating nearly a 50% delay. This is the most common use of percent of delay; looking at the age of the child at the time of testing and the age equivalence they scored on communication and cognitive assessments. This calculation of percent delay can only occur when you know the age at the time of testing and the valid age equivalent score the child had.

There are 12 months in a year. This has to be incorporated in order to turn a child’s age, or age equivalency score into an integer. Remember that age equivalency scores are written in years and months (years; months). If a child’s age is 4 years 6 months, or a child’s age equivalency score is 4;6, that is the same as 4.5 years (as an integer). Take the number of months and divide by 12 months in a year. One can also decide to perform the equations in total months rather than with integers. For example, if a child’s age is 4 years, 6 months, that’s 54 months. Take the number of years and multiply by 12 and add the additional number of months.

Examples:

- If a child's age 5 years, 7 months or AE is 5;7:
 - 5.6 years ($7 \div 12 = .58 = 0.6$, $5 + 0.6 = 5.6$)
 - 67 months ($5 \times 12 + 7 = 67$)
- If a child's age 2 years, 11 months or AE is 2;11:
 - 2.9 years ($11 \div 12 = 0.9$, $2 + 0.9 = 2.9$)
 - 35 months ($2 \times 12 + 11 = 35$)

To determine percent delay:

1. Take the valid, age equivalent score and divide it by the child's age at the time of testing. This tells you the percent they scored on the assessment.
2. Subtract the percent they scored from 1.0 or 100%.

Example A

An 8 year old child at the time of testing scores a valid, age equivalence score of 6. Start by taking 6 divided by 8 and your result is .75 or 75% ($6 \div 8 = .75$). 75% is the percent s/he scored. Subtract .75 from 1.0 or 75% from 100% and you will see their percent delay is .25 or 25% ($1.0 - .75 = .25$ or $100 - 75 = 25\%$).

Example B

A 9 and a half year old child at the time of testing scores a valid, age equivalence score of 6;2.

In Years: Take 6.16 (their age equivalent score in years) divided by 9.5 (their age at testing in years) with a result of .648... - rounded to the nearest hundredths is .65 or 65%. That means they scored 65%. Second, and the most important step, subtract the results from 1.0, so in this case, $1.0 - .65 = .35$ or 35% delay.

In Months: Take 74 (their age equivalent score in months) divided by 114 (their age at testing in months) with a result of .649... - rounded to the nearest hundredths is .65 or 65%. That means they scored 65%. Second, and the most important step, subtract the results from 1.0, so in this case, $1.0 - .65 = .35$ or 35% delay.

Example C

A child's age at the time of testing is 13 years and 4 months. They scored an age equivalent or AE score of 8;9.

In Years: Starting with 8.75, the age equivalent score in years, divided by the age at the time of testing, in this case 13.33 years. $8.75 \div 13.33 = .656$. This rounds up to .66. Now subtract that from 1.0 ($1.0 - .66$) and you get .34 or 34% delay.

In Months: Starting with 105, the age equivalent score in months, divided by the age at the time of testing, in this case 160 months. $105 \div 160 = .656$. This rounds up to .66. Now subtract that from 1.0 ($1.0 - .66$) and you get .34 or 34% delay.

On the functional screen, screeners are required to indicate the results of the valid assessment.

There are three options available:

- Within Normal Limits
- Percent Delay

- Standard Deviation below the norm

For children under a year of age:

- Normal Limits score is considered between 75-125
- Percent Delay must be greater than or equal to 25% to be considered a substantial functional impairment
- Standard Deviation below the norm must be greater than or equal to 1.5 SD below the norm to be considered a substantial functional impairment

For children a year old or older:

- Normal Limits score is considered between 70-130
- Percent Delay must be greater than or equal to 30% to be considered a substantial functional impairment
- Standard Deviation below the norm must be greater than or equal to 2 SD below the norm to be considered a substantial functional impairment

Full Scale Intelligence Quotient

The full scale IQ scores are used as a way to address the over-use and under-use of the diagnosis of mental retardation (MR). There are limitations of IQ testing. The federal definition of MR is a full-scale IQ below 70. Federal guidelines do acknowledge an IQ score error range of 5 points. The WI Department of Health Services has chosen to use 75 as a “cut-off” point instead of 70 in recognition of that error range.

If the clinician conducting the IQ test expressed concern about the results due to the child’s ability to participate in the testing process, don’t use the results of that test. The screener will want to consider the results from the most recent IQ test a child has if they have had multiple tests done. It does not matter how old the IQ test is as long as it is the most current one on record for that child. The screener is required to select the accurate drop down option based on the child’s valid Full Scale IQ Score on the CLTS FS.

Assessment Results within Normal Limits

If the valid norm-referenced standardized test results or IQ score do not represent a substantial functional impairment in communication or learning, the screener must include the results on the functional screen. Once this is entered, the rest of the items under communication or learning will become null and void since it is clear based on actual assessment results that this child’s development is not significantly impaired. These test results are more objective and comprehensive than any of the individual options listed on the functional screen and provide valid and reliable evidence that this child does not meet the required degree of delay for this Instrumental Activity of Daily Living.

6.8 Age Specific ADL/IADL Answer Choices

The following tables provide information and guidance about the ADL/IADL questions on the CLTS FS. The table is organized by ADL/IADL category (Bathing, Dressing, etc.). The columns to the left side of the table indicate the age at which the specific answer choice appears on the CLTS FS. If the column is white, the question applies to that age group; if the column is grey, the question does not apply to that age group. The answer choices are listed in **Bold**. Following

the specific answer choice is an explanation of the question and/or relevant examples. Always consider the answer choice itself first; the examples are only intended to supplement that.

In the following tables, the symbol is used to indicate that if the information listed here is true for the child, the screener would check that box on the CLTS FS.

The symbol is used to indicate that if the information listed here is true for the child, the screener would **not** check that box on the CLTS FS.

This is not an inclusive or exclusive list of information. The children for whom a CLTS FS is completed for are complicated individuals, and every situation has not been represented on the screen or in these instructions. The information provided is meant to offer guidance to the screener. For most of the questions, the answers should be relatively clear once the screener has met the child and reviewed the available documentation. For further clarification, e.g. means “for example” and i.e. means “that is, or “in other words.”

6.9 Bathing

The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene (does not include hair care). For older children, ages 9 and older, this also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash and dry fully.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Not applicable for the purposes of this screen. This option does not appear on the functional screen because young children are expected to require assistance in this category.
												Needs adaptive equipment. <i>Adaptive equipment can include “low-tech” equipment the parents use, such as a baby seat to bathe a baby who cannot sit on her own. Such low-tech or generic equipment count only if it is used to compensate for a child’s physical impairment. Note the term is “needs” equipment, whether or not the child currently has the equipment.</i> <input checked="" type="checkbox"/> Uses shower chair, tub bench, mechanical lift, or any other devices if they are used to compensate for the child’s physical impairment. <input checked="" type="checkbox"/> The parents/caregivers prefer another method and have not obtained adaptive equipment. <input checked="" type="checkbox"/> The child is a year or older and unable to maintain a sitting position unsupported.
												Becomes agitated requiring alternative bathing methods. <input checked="" type="checkbox"/> Becomes unsafe in bathing and needs to be constrained or sponge bathed. <input type="checkbox"/> Takes a shower rather than a bath.

BATHING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Is combative during bathing (e.g., flails, takes two caregivers to accomplish task).</p> <input checked="" type="checkbox"/> Extreme avoidance behaviors that make bathing unsafe for child and/or caregiver. <input checked="" type="checkbox"/> Caregiver is in tub with child because of child's unsafe behavior.
												<p>Needs complete physical assistance.</p> <p>It is expected that children under 5 years old may require some physical assistance, which is why this option is not available to those children. For children 9 years old and older, this also includes children who need an adult to set the water temperature for the child.</p> <input checked="" type="checkbox"/> Requires someone to bathe them (hands on) whether in a bath or shower. Remember, this does not include hair washing.
												<p>Needs to be lifted in and out of bathtub or shower.</p> <input type="checkbox"/> Able to get in and out, but parent chooses to lift them. <input type="checkbox"/> Needs hands on assistance, verbal cues or supervision but can get in and out without others lifting them.
												<p>Needs help getting in and out of bathtub or shower.</p> <input checked="" type="checkbox"/> Needs hands-on assistance, someone to do the task completely, verbal cues or close supervision throughout the task.

BATHING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Needs step-by-step cueing to complete the task.</p> <input checked="" type="checkbox"/> Needs someone with them throughout the bath/shower telling them each step of the process. <input type="checkbox"/> Needs reminder to bathe (e.g., “Don’t forget to take a bath tonight”). <input type="checkbox"/> Needs reminders before the bath takes place (e.g., “remember to wash under your arms”). <input type="checkbox"/> Needs an occasional cue, but not step-by-step instructions. <input type="checkbox"/> Needs prompts throughout the bathing process to stay on task (e.g., “have you washed your body yet?”).
												<p>Lacks an understanding of risk and must be supervised for safety.</p> <input checked="" type="checkbox"/> It is understood that if the screener checked “Is combative during bathing” then this would also be checked.
												<p>Exhibits non-compliant behavior that is extreme to point that child does not perform bathing tasks for at least 5 or more consecutive days.</p> <p><i>This question is intended for children with mental health issues that result in extreme anger and rages that are always present and affect the child’s ability to accomplish tasks that they have the intelligence and developmental ability to complete.</i></p> <input checked="" type="checkbox"/> Refuses to bathe for at least 5 consecutive days each week. <input type="checkbox"/> Refuses to bathe for 5 or more days occasionally but not consistently over the past six months. <input type="checkbox"/> Refuses due to a fine motor limitation. <input type="checkbox"/> Refuses due to a sensory issue. <input type="checkbox"/> Refuses due to a motor coordination issue.

BATHING

6.10 Grooming

Brushing teeth, washing hands and face. Due to variations in hair care by culture, length of hair, etc, hair care is not considered for the purposes of this screen.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Not applicable for the purposes of this screen. This option does not appear on the functional screen because young children are expected to require assistance in this category.
												Is combative during grooming tasks (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task). <input checked="" type="checkbox"/> Exhibits avoidance behavior that is extreme and requires atypical intervention. <input checked="" type="checkbox"/> Needs one caregiver to hold them while another completes the task. <input type="checkbox"/> Runs around the house to avoid grooming tasks. <input type="checkbox"/> Doesn't like grooming tasks and fusses a bit, but not more than some peers.
												Unable to wash hands. <input checked="" type="checkbox"/> Has picture cards or other visual cues and requires assistance from others to use the cues to complete the process. <input checked="" type="checkbox"/> Unable to turn on the faucet, apply soap, and rinse hands under the water. <input type="checkbox"/> Unable to select an appropriate water temperature. <input type="checkbox"/> Independently uses picture cards or other visual cues to complete the process.

GROOMING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Unable to wash hands or face. <input checked="" type="checkbox"/> Unable to turn on the faucet, apply soap, and rinse hands under the water. <input checked="" type="checkbox"/> Unable to wash face using a wash cloth. <input type="checkbox"/> Unable to select an appropriate water temperature.
												Needs physical help with grooming tasks. <input checked="" type="checkbox"/> Needs parent/caregiver to brush teeth. <input checked="" type="checkbox"/> Needs parent/caregiver to wash hands. <input checked="" type="checkbox"/> Needs parent/caregiver to wash face.
												Needs step-by-step cueing during grooming tasks. <input checked="" type="checkbox"/> Needs someone with them throughout the grooming process telling them each step of the process. <input checked="" type="checkbox"/> Needs step-by-step cueing to brush teeth. <input checked="" type="checkbox"/> Needs step-by-step cueing to wash hands. <input checked="" type="checkbox"/> Needs step-by-step cueing to wash face. <input type="checkbox"/> Needs reminders to groom self.

GROOMING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
												<p>Exhibits non-compliant behavior that is extreme to point that child does not brush their teeth for at least 5 or more consecutive days.</p> <p><i>This question is intended for children with mental health issues that result in extreme anger and rages that are always present and affect the child's ability to accomplish tasks that they have the intelligence and developmental ability to complete.</i></p> <p><input checked="" type="checkbox"/> Does not brush teeth for at least 5 consecutive days each week.</p> <p><input type="checkbox"/> Does not brush teeth for 5 or more days occasionally but not consistently over the past six months.</p> <p><input type="checkbox"/> Refuses due to a fine motor limitation.</p> <p><input type="checkbox"/> Refuses due to a sensory issue.</p> <p><input type="checkbox"/> Refuses due to a motor coordination issue.</p> <p><input type="checkbox"/> Does not wash hands or face for several days – not a serious hygiene/health issue.</p>

GROOMING

6.11 Dressing

The ability to dress as necessary. This does not include the fine motor coordination for buttons and zippers.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Has physical characteristics that make dressing very difficult--such as contractures, extreme hypotonia or extreme hypertonia.</p> <input checked="" type="checkbox"/> This can include difficulty with baby's diaper changes.
												<p>Does not assist with dressing by helping to place arms in sleeves or legs into pants.</p> <input checked="" type="checkbox"/> Unable to assist with arms or legs (or both). <input type="checkbox"/> Can assist in their own dressing tasks.
												<p>Unable to pull off hats, socks, and mittens.</p> <input checked="" type="checkbox"/> Unable to take off all of these items. <input checked="" type="checkbox"/> Needs someone to get the item partially off, then the child is considered unable to pull off item. <input type="checkbox"/> Can take off any one of the mentioned items (e.g., can pull off socks but not hats or mittens).
												<p>Unable to undress self independently.</p> <input checked="" type="checkbox"/> Unable to take off any one item that is worn on a regular basis. <input type="checkbox"/> Unable to undo buttons but can pull buttoned shirts off over head. <input type="checkbox"/> Unable to undo fasteners on the backs of clothing.

DRESSING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
												<p>Needs physical assistance with getting clothing on. This does not include fasteners such as buttons, zippers and snaps.</p> <p>At this age it is expected that typically developing children can dress themselves.</p> <p><input checked="" type="checkbox"/> A parent/caregiver needs to hold pants while a child steps into them or help pull a shirt over the child's head.</p> <p><input checked="" type="checkbox"/> Puts clothing on by self but clothing is inside out, or backwards (not including underwear), or shoes are on the wrong feet.</p> <p><input type="checkbox"/> Can dress independently but needs help with fine tuning (e.g. tucking shirt in, zipping pants, buttoning shirt).</p>

DRESSING

6.12 Eating

The ability to eat and drink by finger feeding or using routine or adaptive utensils. The ability to swallow sufficiently to obtain adequate intake. Does not include cooking food or preparing it for consumption (cutting food into bite size pieces or pureeing if needed).

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Receives tube feedings or TPN.
												Needs help with tube feedings or TPN. <input type="checkbox"/> A teen independently self-administers tube feedings. In this case, the screener would check “Receives tube feedings or TPN,” but not “receives help with” them.
												Requires more than three hours per day for feeding or eating. <input checked="" type="checkbox"/> Can feed self but is so resistant or slow that the child is at risk of tube feedings to obtain adequate nutrition. <input type="checkbox"/> Toddlers who nibble all day long. <input type="checkbox"/> Children who are picky eaters or eat “junk food” all day. <input type="checkbox"/> Food preparation time for special diets.
												Requires more than one hour per feeding. <input checked="" type="checkbox"/> Takes a great deal of time to feed orally (nurse or bottle fed). <input type="checkbox"/> Is tube fed.

EATING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Needs to be fed. <input checked="" type="checkbox"/> Cannot feed self enough (orally) to obtain adequate nutrition. <input type="checkbox"/> Is tube fed. Instead, check “Receives tube feedings or TPN,” and, if true, "Needs help with tube feedings or TPN.” <input type="checkbox"/> Able to feed self but makes a mess or doesn’t use utensils so the parent prefers to feed child. <input type="checkbox"/> Able to feed self but parent prefers to feed the child.
												Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications. <input checked="" type="checkbox"/> Needs to be monitored for life-threatening choking incidents. <input checked="" type="checkbox"/> Has Prader-Willi Syndrome and all food access must be controlled. <input type="checkbox"/> Is monitored because of concerns the child will choke but the child has no history of choking while eating. <input type="checkbox"/> Will stuff mouth with food often resulting in gagging or vomiting. <input type="checkbox"/> Has current eating disorder requiring one-on-one monitoring at meals. <input type="checkbox"/> Avoids certain foods, gags or spits out foods due to oral sensitivities. <input type="checkbox"/> Parents/caregivers thicken liquids for the child and then they can be left to drink without one-on-one monitoring. <input type="checkbox"/> Has food cut into bite size pieces but does not require monitoring during the meal.

EATING

6.13 Toileting

The ability to use a toilet or urinal, transferring on/off a toilet, changing menstrual pads, and pulling down/up pants.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Applicable questions for the purposes of this screen have been covered on the Health-Related Services Section.
												<p>Has no awareness of being wet or soiled.</p> <input checked="" type="checkbox"/> Does not know or care that their diaper/underpants are wet or soiled.
												<p>Does not use toilet/potty chair when placed there by a caregiver.</p> <input checked="" type="checkbox"/> Will sit on toilet/potty chair but does not use it to void.
												<p>Incontinent during the day (of bowel and/or bladder).</p> <p>When one does not have physical control of bowel or bladder. When considering whether child is incontinent most of the time, incontinence should be counted by days, not the number of times the child voids each day.</p> <input checked="" type="checkbox"/> Is incontinent once a day on school days (that's most days throughout the week). <input checked="" type="checkbox"/> Has accidents because s/he did not get to bathroom on time. <input checked="" type="checkbox"/> Is wet between self-cathing intervals. <input type="checkbox"/> Uses pull ups to have bowel movements but has control of his/her bowel. <input type="checkbox"/> Behavioral problems involving voiding or defecating. <input type="checkbox"/> Uses a catheter with some leakage.

TOILETING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Needs physical help (other than wiping).</p> <input checked="" type="checkbox"/> Child consistently needs hands on assistance to use toilet. <input type="checkbox"/> Child is not able to wipe him/herself after a bowel movement but is otherwise independent in toileting. <input type="checkbox"/> Needs assistance getting on or off toilet. <input type="checkbox"/> Uses adaptive equipment with toileting (for example: hand bars)
												<p>Needs physical help, step-by-step cues, or a toileting schedule.</p> <p>A “<u>toileting schedule</u>” is when other people must take the child to the toilet at regular times to reduce incontinence. This does not include a child who needs verbal reminders to use the bathroom at regular times.</p> <input checked="" type="checkbox"/> Parent/caregiver performs catheterization or assists the child with cathing. <input checked="" type="checkbox"/> Needs help wiping following a bowel movement. <input checked="" type="checkbox"/> Needs help changing menstrual pads. <input type="checkbox"/> Requests a pull up or diaper for the purpose of defecating in it. <input type="checkbox"/> Can self-cath at regularly scheduled intervals. <input type="checkbox"/> Parent/caregiver wakes a child to urinate at the same time every night to prevent bedwetting. <input type="checkbox"/> Needs assistance getting on or off toilet. <input type="checkbox"/> Uses adaptive equipment with toileting (for example: hand bars)
												<p>Incontinent of bowel during the night.</p>

TOILETING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Incontinent (of bowel and/or bladder).</p> <p>When one does not have physical control of bowel or bladder. When considering whether child is incontinent most of the time, incontinence should be counted by days, not the number of times the child voids each day.</p> <p><input checked="" type="checkbox"/> Is incontinent once a day on school days (that's most days throughout the week).</p> <p><input checked="" type="checkbox"/> Has accidents because s/he did not get to bathroom on time.</p> <p><input checked="" type="checkbox"/> Is wet between self-cathing intervals.</p> <p><input type="checkbox"/> Uses pull ups to have bowel movements but has control of his/her bowel.</p> <p><input type="checkbox"/> Behavioral problems involving voiding or defecating.</p> <p><input type="checkbox"/> Uses a catheter with some leakage.</p>

TOILETING

6.14 Mobility

The ability to move between locations in the individual's living environment. For children, this includes home and school. Mobility includes walking, crawling, or wheeling oneself around at home or at school. For functional eligibility purposes, mobility does not include transporting oneself between buildings or moving long distances outdoors.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Not applicable for purposes of this screen. This option does not appear on the functional screen because young children are expected to require assistance in this category.
												Unable to maintain a sitting position when placed. <input checked="" type="checkbox"/> Pillows or props are used and the child still cannot support their own trunk <input type="checkbox"/> Pillows or props are used and the child is able to maintain a sitting position.
												Unable to move self by rolling, crawling, or creeping. <input checked="" type="checkbox"/> Cannot move self. <input type="checkbox"/> Can do one but not the others.
												Unable to pull to stand.
												Unable to sit alone. <input checked="" type="checkbox"/> Needs pillows or props to support the child in a seated position. <input type="checkbox"/> Needs parent or caregiver to place child in a seated position.
												Unable to creep or crawl. <input type="checkbox"/> Able to creep but not crawl. <input type="checkbox"/> Able to crawl but not creep.

MOBILITY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Requires a stander or someone to support the child’s weight in a standing position.</p> <input checked="" type="checkbox"/> Cannot stand even if they have something to hold onto. <input checked="" type="checkbox"/> Does not have the strength in their legs to support their own weight. <input type="checkbox"/> Can support their own weight, for example, cruising on furniture or using a walker.
												<p>Uses a wheelchair or other mobility device not including a single cane.</p> <input checked="" type="checkbox"/> Uses a mobility device that is generic or specialized equipment to compensate for a physical impairment in mobility. <input checked="" type="checkbox"/> Uses a wheelchair or walker. <input checked="" type="checkbox"/> Uses generic equipment (e.g., a stroller), <u>only</u> if it is used to compensate for the child’s physical mobility impairment. <input type="checkbox"/> Uses AFOs, braces, or a single cane.
												<p>Unable to take steps holding on to furniture.</p> <input checked="" type="checkbox"/> Can pull to stand with the aid of furniture but then cannot take a step. <input type="checkbox"/> Can take a small number of steps. <input type="checkbox"/> Cannot pull to stand. Instead the screener would check “Requires a stander or someone to support the child’s weight in a standing position.”

MOBILITY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not walk or needs physical help to walk.</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Needs to hold someone's hand in order to walk. <input checked="" type="checkbox"/> Requires another person to help hold the child up while they walk. <input type="checkbox"/> Can cruise holding onto furniture. <input type="checkbox"/> Walks independently with equipment such as a walker. <input type="checkbox"/> Fatigues while walking. <input type="checkbox"/> Can walk but falls down often.

MOBILITY

6.15 Transfers

The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. This excludes transfers into bathtub or shower or on and off the toilet, because those are captured in bathing and toileting ADLs. This does not include transfers in/out of a car or other vehicle.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Not applicable for purposes of this screen. This option does not appear on the functional screen because young children are expected to require assistance in this category.
												Needs to be transferred.
												Needs physical help with transfers.
												Uses a mechanical lift. <input checked="" type="checkbox"/> Uses a mechanical lift with or without assistance.

TRANSFERS

6.16 Communication

Hearing Impairments

Many of the questions in this category are related to auditory/verbal communication. If a child has a known hearing impairment some interpretation will be required to answer the questions correctly. Consider the child's primary method of communication when answering these questions. If they communicate primarily through sign language due to a hearing impairment, then complete the questions with that understanding. For example, for a child who is deaf, when asked "Does not use more than 10 meaningful words or word approximations," the screener would inquire if they can sign 10 words. The same holds true for a child who uses a communication device as their primary mode of communication. That would not be the case for example for a child with Down syndrome who has a speech delay and is enhancing their communication with sign language. For that child, their primary method of communication is still verbal.

Some questions cannot be modified for a child with a severe hearing impairment. In these cases, check the question appropriately given this disability. For example, when asked, "Does not startle, jump or blink to sudden, loud, unexpected noises" it is expected that a child with a significant hearing impairment would have this item checked. Another example is, "Does not imitate environmental sounds through any means." If a child cannot demonstrate the communication skill with consideration of their primary mode of communication, then the item is checked on the screen.

Non-Verbal / Use of Communication Devices

Many of the questions in this category are related to auditory/verbal communication. If a child has a known significant language disorder that has resulted in the use of an alternative communication system, some interpretation will be required to answer the questions correctly. Please consider the child's primary method of communication. If they communicate using a communication device, then complete the questions with that understanding. For example, for a child who is non-verbal and uses a Dynamite to express themselves, when asked "Does not join familiar words into phrases (e.g., "me drink," "red truck")," the screener would inquire if they are combining words on their Dynamite.

Assessment of 30% delay or two standard deviations

The following is a list of tools that are norm referenced for receptive and expressive language. Select the correct tool from the pull down menu on the CLTS FS. Indicate the date (MM/YYYY) that the assessment was completed.

[] indicates child's age at which this tool can be used and considered accurate. Any numbers written with decimal points indicates the age in [years.months]. The latest editions of the test should always be used when available.

Acceptable tools for Receptive and Expressive Communication

Clinical Evaluation of Language Fundamentals (CELF) [5 – 21] or Preschool (CELF-P) [3 – 6.11]

Comprehensive Assessment of Spoken Language (CASL) [3 – 21]

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Comprehensive Receptive and Expressive Vocabulary Test (CREVT) [4 – 89]
 Early Language Milestone Scale (ELMS) [Birth – 36 months]
 Expressive and Receptive One-Word Picture Vocabulary Test (ROWPVT-2) [2 – 18]
 MacArthur Communicative Developmental Inventories (CDIs) [8 – 30 months]
 Miller Assessment for Preschoolers (MAP) [2.9 - 5.8]
 Oral and Written Language Scales (OWLS) [3 – 21] – Only use Listening Comprehension Scale and Oral Expression Scale results
 Preschool Language Scale (PLS) [Birth – 6]
 Reynell Developmental Language Scales [1 – 6.11]
 Sequenced Inventory for Communication Development (SICD) [4 months – 4]
 Test of Adolescent and Adult Language (TOAL) [12 – 24]
 Test of Early Language Development (TELD) [2 – 7.11]
 Test of Language Competence (TLC) [5 – 18.11]
 Test of Language Development - Intermediate (TOLD-I) [8 – 12] or Primary (TOLD-P) [4 – 8.11]

The following are commonly used assessments that DO NOT qualify as norm-referenced tools of Expressive and Receptive Communication:

1. Not Norm-Referenced, Standardized Tools:
 - a. Assessment of Basic Language and Learning Skills
 - b. Brigance Diagnostic Inventory
 - c. Carolina Curriculum for Infants/Toddlers with Special Needs
 - d. Child Curriculum Inventory Profile
 - e. Denver Developmental Screen
 - f. Developmental Assessment for Individuals with Severe Disabilities
 - g. Developmental Assessment of Young Children
 - h. Developmental Observation Checklist System (DOCS)
 - i. Early Learning Accomplishment Profile (E-LAP)
 - j. Measurement of Language Utterance (MLU)
 - k. Non Speech Test for Expressive and Receptive Language
 - l. Portage Guide to Early Education
 - m. Receptive Expressive Emergent Language Scale (REEL)
 - n. Rosetti Infant Toddler Language Scale
 - o. Transdisciplinary Play Based Assessment

2. Communication Assessments that do not measure Expressive or Receptive Communication:
 - a. Braken Basic Concept Scale
 - b. Communication Abilities Diagnostic Test (CADeT)
 - c. Gard Gillman and Gorman Pragmatic Language Scale
 - d. Goldman Fristoe Test of Articulation
 - e. Greenspan-Lewis Affect Basic Language Curriculum
 - f. Language Processing Test (LPT)
 - g. Northwestern Syntax Screening Test
 - h. Peabody Picture Vocabulary Test (PPVT)
 - i. Test of Early Reading Ability (TERA)
 - j. Test of Pragmatic Language (TOPL)
 - k. Test of Word Finding (TWF)

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3. Tools that measure something other than Expressive and Receptive Language but contain sub-categories regarding Communication skills. These are not accepted because the purpose of the tool is not to measure Expressive and Receptive Language. There is a communication subtest that measures the influence that communication has on behavior or intelligence or achievement or development but cannot stand alone as an assessment of communication. These often fall into the category of screening tools rather than full assessments.
 - a. Adaptive Behavior Assessment System
 - b. Adaptive Behavior Scale
 - c. Adolescent Test of Problem Solving
 - d. Autism Rating Scale
 - e. Battelle Developmental Inventory (BDI)
 - f. Bayley Scales of Infant Development
 - g. Behavioral Language Assessment Form
 - h. Differential Ability Scale (DAS)
 - i. Early Learning Measure (ELM)
 - j. Eau Claire Child Observation Recording Tool (EC-CORT)
 - k. Kaufman Assessment Battery for Children
 - l. Kaufman Brief Intelligence Test
 - m. Kaufman Survey of Early Academic and Language Skills
 - n. Mullen Scales of Early Learning
 - o. Psychoeducational Profile Revised
 - p. Scales of Independent Behavior
 - q. Vineland Adaptive Behavior Scales
 - r. Wechsler Individual Achievement Test (WIAT)
 - s. Wechsler Intelligence Scale for Children (WISC)
 - t. Wechsler Preschool and Primary Scales of Intelligence
 - u. Wisconsin Knowledge and Concepts Examination
 - v. Woodcock-Johnson Test of Achievement
 - w. Woodcock-McGrew-Weder Mini-Battery of Achievement
 - x. WRAT

6.16 Communication

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	
												<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
												<p>A norm referenced assessment in receptive language within the last 3 months. (A substantial functional impairment is defined by results that indicate a delay of 25% or greater or 1.5 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See '6.7 Communication and Learning Assessments' for further instruction.</i></p>
												<p>A norm referenced assessment in expressive language within the last 3 months. (A substantial functional impairment is defined by results that indicate a delay of 25% or greater or 1.5 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See '6.7 Communication and Learning Assessments' for further instruction.</i></p>
												<p>A norm referenced assessment in receptive language within the last 6 months. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See '6.7 Communication and Learning Assessments' for further instruction.</i></p>
												<p>A norm referenced assessment in expressive language within the last 6 months. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See '6.7 Communication and Learning Assessments' for further instruction.</i></p>
												<p>A norm referenced assessment in receptive language within the last year. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See '6.7 Communication and Learning Assessments' for further instruction.</i></p>

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0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>A norm referenced assessment in expressive language within the last <u>year</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>A norm referenced assessment in receptive language within the last <u>three (3) years</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>A norm referenced assessment in expressive language within the last <u>three (3) years</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>Does not startle, jump or blink to sudden, loud, unexpected sounds.</p> <p><input checked="" type="checkbox"/> Does not react in any way to sudden sounds such as fire engines, slamming a door, a dog barking, and a garbage truck.</p>
												<p>Does not make any vocal sounds (includes crying).</p> <p><input checked="" type="checkbox"/> Cannot cry out for help (e.g., a child with a tracheostomy).</p>

COMMUNICATION

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not react to changes in tone of voice.</p> <p><input checked="" type="checkbox"/> Does not turn head in the direction of the speaker when there is an obvious change in tone of voice.</p> <p><input checked="" type="checkbox"/> Does not react to the change from a happy, playful voice to a stern, upset tone of voice.</p> <p><input checked="" type="checkbox"/> Does not interpret visual change from a happy face to a mad face (especially for children who are hearing impaired)</p> <p><input checked="" type="checkbox"/> Does not engage any level of eye contact when spoken to.</p>
												<p>Does not express his/herself through vocal, visual or gesture exchange.</p> <p><input checked="" type="checkbox"/> Does not convey needs to parent/caregiver.</p> <p><input type="checkbox"/> Expresses needs in only one way (e.g., gesture but not vocal or visual).</p>
												<p>Does not jabber or babble as if they are trying to say something.</p> <p><input checked="" type="checkbox"/> Does not make noises as if they are talking.</p> <p><input type="checkbox"/> Uses variations in intonation, sentence patterns (breaks in babble) or multiple consonants sounds.</p> <p><input type="checkbox"/> Jabber or babble sounds like speech.</p> <p><input type="checkbox"/> Doesn't require another person to engage in conversation.</p>
												<p>Does not respond to simple requests (e.g., no, stop, come here, give me, look).</p> <p><input checked="" type="checkbox"/> Does not seem to notice that someone has said (signed) something to them.</p> <p><input type="checkbox"/> Understands the request but does not comply.</p>

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0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not point to or look at any familiar objects or people when asked.</p> <p><i>Examples – nuk, bottle, cup, dog, cat, blanky, mama, dada, ball, car.</i></p> <p><input checked="" type="checkbox"/> Does not respond to requests to look at the puppy (or other items in the child’s day to day environment).</p>
												<p>Does not imitate environmental sounds through any means.</p> <p><i>Examples – animal sounds, up-up-up when walking up the stairs, honk-honk, beep-beep, brrr = car engine.</i></p> <p><input checked="" type="checkbox"/> Does not copy others when they make silly, familiar sounds.</p> <p><input type="checkbox"/> Doesn’t know the name of animals but can identify them by the sounds they make.</p>
												<p>Does not use more than 10 meaningful words or word approximations.</p> <p><input checked="" type="checkbox"/> Only says words when repeating what other’s say. Does not use spontaneous speech.</p> <p><input type="checkbox"/> People familiar with the child understands the word approximations.</p> <p><input type="checkbox"/> Is not understood by strangers.</p> <p><input type="checkbox"/> Uses word approximations such as “bah” for “bottle.”</p>
												<p>Does not join familiar words into phrases (e.g., “me drink,” “red truck”, “baby cry”, “no juice”).</p> <p><input checked="" type="checkbox"/> Uses only phrases that have no meaning to the people familiar to the child. For example, “bottle truck,” “baa quack.”</p> <p><input checked="" type="checkbox"/> Uses primarily single words to communicate although parents/caregivers have heard a few two-word phrases emerging.</p> <p><input type="checkbox"/> Only combines words that are commonly taught together, almost as one word, such as: bye-bye, thank you, all done, or all gone.</p>

COMMUNICATION

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not point to or look at 3 familiar objects or people when asked.</p> <p><i>Examples – nuk, bottle, cup, dog, cat, blanky, mama, dada, ball, car.</i></p>
												<p>Does not follow two step instructions that are related and are not routine.</p> <p><input checked="" type="checkbox"/> Follows through with one instruction and cannot retain second instruction.</p> <p><input checked="" type="checkbox"/> Child is asked to “go to your room and bring back your bunny” and gets to their room and does not come back with their bunny.</p> <p><input checked="" type="checkbox"/> Does not follow any instructions.</p>
												<p>Does not use at least 50 words.</p> <p><input type="checkbox"/> Uses 50 or more words but can only be understood by people familiar with the child.</p>
												<p>Does not use “mine” to indicate possession.</p>
												<p>Does not understand any preposition (e.g., in, on, under) in unfamiliar single step instructions.</p> <p><input checked="" type="checkbox"/> Cannot follow any of the following: 1) put the block under the chair, 2) put the toy car on the TV, or 3) put the toy in your shoe.</p> <p><i>For children who are non-ambulatory: Using two pictures; one of a ball on a table and the other of a ball under the table, have the child point to/look at the one requested.</i></p> <p><input type="checkbox"/> Uses at least 3 prepositions but not the ones listed in the example.</p>
												<p>Does not combine 3 or more words into a meaningful sentence.</p> <p><input checked="" type="checkbox"/> Uses primarily single words to communicate although parents/caregivers have heard three word phrases emerging.</p> <p><input type="checkbox"/> Can only be understood by familiar people.</p>

COMMUNICATION

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not understand at least 3 prepositions (e.g., in, on, under) in unfamiliar single step instructions.</p> <p><i>Examples – put the block under the chair, put the toy car on the TV, or put the toy in your shoe.</i></p> <p><i>For children who are non-ambulatory: Using two pictures; one of a ball on a table and the other of a ball under the table, have the child point to/look at the one requested.</i></p>
												<p>Does not ask for objects by naming them.</p> <p>May be through verbal language, communication device, sign language, etc. Cannot be checked for a child who pulls caregiver to the object.</p>
												<p>Does not combine 6 or more words into meaningful sentences.</p>
												<p>Is not understood by familiar people that have infrequent contact with the child.</p> <p><i>Examples include – gym teacher, principal, neighbor, librarian grandma and grandpa. People the child sees in school or their neighborhood but who do not engage with the child on a daily basis.</i></p>
												<p>Does not follow 3-step instructions that are related and are not routine.</p> <p><i>Examples –</i></p> <p>1 - take your dishes to the sink, 2 - rinse them and 3 - place them in the dishwasher.</p> <p>1 – pick up your toy, 2 – take it to your room and 3 – put it in your toy box.</p> <p>For children who are non-ambulatory: 1 - tell me your name, 2 - address and 3 - birth date.</p>

COMMUNICATION

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>For children who are non-ambulatory and non-verbal: 1 - <i>point to your eyes,</i> 2 - <i>nose and</i> 3 - <i>mouth.</i></p> <p><i>Do not check if child understands the request but refuses to comply. It doesn't matter what order they complete the tasks in. Do check if the only instructions a child can follow are part of their daily routine.</i></p> <p><input checked="" type="checkbox"/> <u>Cannot follow 3 unrelated</u> instructions such as, "Turn off the TV, put your books away and make yourself a snack" even if s/he is able to follow a series of 3 <u>related</u> instructions such as, "Collect the garbage from upstairs, tie the bags tight and put them on the curb."</p> <p><input type="checkbox"/> Able to follow non-sequential instructions such as, "Don't forget your lunch, go to Johnny's house after school and remember we are going to the YMCA tonight."</p>
												<p>Does not follow 2 single step instructions given at the same time that are unrelated and are not routine.</p> <p><i>Examples –</i></p> <p>1 - <i>go get your library book and</i> 2 - <i>put your clothes in the hamper.</i> 1 - <i>put your bike away and</i> 2 - <i>feed the dog.</i></p> <p>For children who are non-ambulatory: 1 - <i>point to your nose and</i> 2 - <i>tell me the day of the week.</i></p> <p>For children who are non-ambulatory and non-verbal: 1 - <i>point to the window and</i> 2 - <i>nod your head "yes".</i></p> <p><i>Do not check if child understands the request but refuses to comply. It doesn't matter what order they complete the tasks in.</i></p>
												<p>Does not use language to share information other than basic needs or wants.</p> <p><i>Examples include – giving directions, describing feelings, providing details.</i></p>

COMMUNICATION

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-17 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Is not understood by strangers.</p> <input type="checkbox"/> Able to communicate messages to others even though some words may be unclear. <input type="checkbox"/> Child is fluent in ASL or signed English.

COMMUNICATION

6.17 Learning

Compromising Impairments

Under the category of Learning, the CLTS FS is capturing cognitive development. The questions have been stated in broad terms to try to account for different developmental issues affecting children. If a child has limitations that mask their cognitive development, try to determine the actual cognitive ability. If a child has a significant vision impairment, has a significant hearing impairment, or has a complex physical disability that compromises the child's ability to demonstrate their intelligence, consider the question in light of that impairment. For example, "Does not seek objects that were hidden" is a question asked for a 13-18 month old child. If a child is blind, this skill may not be possible to measure. If a child has a physical disability that limits their movement, we may still be able to tell that the child understands object permanence by seeing if they continue to look in the direction of a toy that was hidden or start looking away as if the toy disappeared. When the child's compromising impairments result in not being able to adequately measure their cognitive impairment, make note of the situation in the notes section on that page and contact State Clinical Staff for further assistance.

The following is a list of tools that are norm referenced for cognitive development. Select the correct tool from the pull down menu on the CLTS FS.

[] indicates child's age at which this tool can be used and considered accurate. Any numbers written with decimal points indicates the age in years.months.

* indicates an IQ test

The latest editions of the test should always be used when available.

- Battelle Developmental Inventory [Birth - 8]
- Bayley Scales of Infant Development [1 month - 42 months]
- Cognitive Abilities Scale (CAS) [3 months - 3]
- Comprehensive Test of Nonverbal Intelligence (CTONI) [6 - 18.11]
- Differential Ability Scales (DAS) [2.6 - 17.11]
- Kauffman Adolescent & Adult Intelligence Test (KAIT) [11 - 85]*
- Kaufman Assessment Battery for Children (KABC) [2.5 - 12.5]*
- Leiter International Performance Scale - Revised (Leiter-R) [2 - adult]
- McCarthy Scales of Children's Abilities [2.5 - 8.5]
- Merrill-Palmer Revised Scales of Development (M-P-R) [Birth - 6.6]
- Miller Assessment for Preschoolers (MAP) [2.9 - 5.8]
- Mullen Scales of Early Learning (MSEL) [Birth - 42]
- Primary Test of Cognitive Skills (PTCS) [Grades K-1]

LEARNING

- Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI) [adolescence - adult]
- Stanford-Binet Intelligence Scales (SB) [2 - Adult]*
- Test of Nonverbal Intelligence (TONI-3) [6 - 89.11]
- Universal Nonverbal Intelligence Test (UNIT) [5 – 17]
- Wechsler Intelligence Scale for Children (WISC) [6 - 16] *
- Wechsler Preschool Primary Scale of Intelligence (WPPSI) [2 - 6] *
- Woodcock Johnson III - Tests of Cognitive Skills (WJ III COG) [2 – 90+]

The following are commonly used assessments that DO NOT qualify as norm-referenced tools of Cognition:

1. Not Norm Referenced, Standardized tools:
 - a. Assessment, Evaluation, and Programming System (AEPS)
 - b. Brigance Diagnostic Inventory of Early Development
 - c. Brigance Inventory of Basic Skills
 - d. California Ordinal Scales of Development
 - e. Carolina Curricula (CCITSN or CCPSN)
 - f. Early Learning Accomplishment Profile
 - g. Hawaii Early Learning Profile Assessment Checklist (HELP)
 - h. Southern California Ordinal Scales of Development
 - i. Transdisciplinary Play-Based Assessment (TBA)

2. Achievement Tests that do not test of Cognitive Ability
 - a. Boehm Test of Basic Concepts
 - b. Cognitive Abilities Test (CogAT)
 - c. Developmental Assessment of Young Children (DAVC)
 - d. Kaufman Test of Educational Achievement (KTEA)
 - e. Measures of Academic Progress (MAPS)
 - f. Peabody Individual Achievement Test Revised (PIAT-R)
 - g. Test of Cognitive Skills (TCS)
 - h. Wechsler Individual Achievement Test
 - i. Wide Range Achievement Test (WRAT)
 - j. Wisconsin Alternative Assessment
 - k. Wisconsin Knowledge and Concepts Examination
 - l. Woodcock-McGrew-Werder Mini-Battery of Achievement (MBA)
 - m. Young Children's Achievement Test (YCAT)
 - n. Woodcock-Johnson Test of Achievement

3. Measurement of Behavior or Adaptive Skills (not tests of Cognitive Ability)
 - a. Achenbach’s Child Behavior Checklists (CBCL)
 - b. Adaptive Behavior Assessment System
 - c. Adaptive Behavior Scales (ABS)
 - d. Behavioral Style Questionnaire
 - e. Child Development Inventory
 - f. Developmental Observation Checklist System (DOCS)
 - g. Developmental Profile II (DPII)
 - h. Early Coping Inventory (ECI)
 - i. Infant/Toddler Sensory Profile
 - j. Infant Toddler Developmental Assessment (IDA)
 - k. Psycho-Educational Profile-Revised (PEP-R)
 - l. Scales of Independent Behavior-Revised (SIB-R)
 - m. Scales of Independent Behavior—Revised (SIB-R)
 - n. Vineland Adaptive Behavior Scales (VABS)
 - o. Wisconsin Behavioral Rating Scale
 - p. Woodcock-Johnson Scales of Independent Behavior

4. Measurement of something other than Cognitive Ability
 - a. Clinical Evaluation of Language Fundamentals (CELF)
 - b. Columbia Mental Maturity Scale (CMMS)
 - c. Gates Macginitie
 - d. Integrated Technology Literacy Skills
 - e. Preschool Language Scale – 4 (PLS-4)
 - f. Receptive One-Word and Expressive One-Word Picture Vocabulary Test
 - g. Receptive-Expressive Emergent Language Test (REEL)
 - h. San Diego Quick Assessment
 - i. Scholastic Inventory Reading
 - j. Test of Auditory Reasoning and Processing Skills (TARPS)
 - k. Test of Problem Solving-Revised (TOPS-R)

5. Diagnostic Tests
 - a. Gilliam Autism Rating Scale
 - b. Global Assessment of Functioning (GAF)
 - c. Greenspan Developmental Checklist

6. No “Brief” Testing Accepted
 - a. Kaufman Brief Intelligence Test
 - b. Wechsler Abbreviated Scale of Intelligence

6.17 Learning

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
												<p>A norm referenced assessment in cognition within the last <u>3 months</u>. (A substantial functional impairment is defined by results that indicate a delay of 25% or greater or 1.5 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>A norm referenced assessment in cognition within the last <u>6 months</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>A norm referenced assessment in cognition within the last <u>year</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>A norm referenced assessment in cognition within the last <u>three (3) years</u>. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 Standard Deviations (SD) below the mean.)</p> <p><i>See note above regarding specific assessment tools that are accepted for this question. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>
												<p>Has a valid full scale IQ. (A substantial functional impairment is defined by a full scale IQ score of 75 or less.)</p> <p><i>Consider most recent valid Full Scale IQ score if child has had more than one test done. It doesn’t matter how old the test is as IQ tests are often not repeated throughout childhood. See ‘6.7 Communication and Learning Assessments’ for further instruction.</i></p>

LEARNING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Is not soothed when needs are met.</p> <p><input checked="" type="checkbox"/> No matter what is offered (food, diaper change, hugs and snuggles) the child is not soothed.</p> <p><input checked="" type="checkbox"/> Cries throughout the day and night without any predictable pattern.</p> <p><input type="checkbox"/> Is a “colicky” or “fussy” baby, but can be soothed with some effort to meet needs.</p> <p><input type="checkbox"/> Is fussy for a fairly predictable period of almost every day.</p>
												<p>Does not show an interest in people or objects.</p>
												<p>Does not seek objects that were hidden.</p> <p><i>This is a common milestone of typical development called <u>object permanence</u>. Intended to determine if a child understands that an object still exists even if it disappears from sight.</i></p> <p><input checked="" type="checkbox"/> Once an object disappears from sight, the child does not show any indication that they understand that the object itself still exists.</p> <p><input type="checkbox"/> Follows an object with an eye gaze as it is put it under a blanket and then continues to look at the blanket. This is important to consider for children with physical limitations.</p>
												<p>Cannot intentionally bang, shake or drop toys.</p> <p><input checked="" type="checkbox"/> Grasps toys but does not “play” with toys.</p> <p><input type="checkbox"/> Drops toys by accident but not with intention.</p> <p><input type="checkbox"/> Engages in these activities <u>only</u> as self stimulation.</p>
												<p>Cannot imitate gestures or activities (e.g., wave bye-bye, clap hands, make faces).</p> <p><input checked="" type="checkbox"/> Does not imitate these activities following a demonstration.</p> <p><input type="checkbox"/> Engages in these activities <u>only</u> as self stimulation.</p>

LEARNING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not know any body parts on self or others.</p> <input checked="" type="checkbox"/> Does not respond to “Where’s your nose?” or other similar questions.
												<input type="checkbox"/> When asked about a body part the child shows you on a doll, in pictures, on themselves or on you? <input type="checkbox"/> Only knows one body part.
												<p>Does not place objects in containers during play.</p> <input type="checkbox"/> Places objects in containers seemingly by accident while playing.
												<input type="checkbox"/> Will not place objects in containers based on the direction of others but will do it on their own at other times. <input type="checkbox"/> Does not have the physical ability to place objects in a container due to physical limitations.
												<p>Does not connect a familiar action with an expected outcome (e.g., starting the water means a bath or shower).</p> <input checked="" type="checkbox"/> Does not know that they are about to go outside when someone brings them a coat.
												<p>Does not know at least 3 body parts.</p> <input checked="" type="checkbox"/> Knows the “Head, Shoulder, Knees & Toes” song but cannot identify body parts at any other time.
												<input type="checkbox"/> Only knows 3 parts of the face.
												<p>Cannot match any basic shapes.</p> <i>Examples: putting a round lid on a pot, putting a square lid on Tupperware.</i>
												<input checked="" type="checkbox"/> Given a wooden puzzle with three pieces, a square, circle and a triangle, the child cannot place any piece correctly.
												<input type="checkbox"/> Child with quadriplegia can match shapes by sight. <input type="checkbox"/> Given a wooden puzzle with three pieces, a square, circle and a triangle, the child can place one piece correctly consistently.

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Cannot identify objects in pictures by naming or pointing.
												<p>Cannot match 3 shapes or 3 colors.</p> <p><i>Examples for shapes: sorting blocks, using a shape sorter, matching animal crackers, sorting pictures or stickers of shapes.</i></p> <p><i>Examples for colors: sorting socks, mittens, M&Ms, crayons, vitamins.</i></p>
												<p>Cannot rote count to 10 without mistakes.</p> <p><input checked="" type="checkbox"/> Counts to ten but usually misses a couple of numbers along the way.</p> <p><input type="checkbox"/> Counts to ten consistently but doesn't know the value of the numbers.</p>
												Cannot maintain an attention span of at least three minutes for an enjoyable activity (not including self-stimulating behavior).
												<p>Cannot accurately identify at least 7 colors.</p> <p><i>Colors include: red, green, blue, yellow, orange, purple/violet, brown, white, black, grey, pink, silver, gold, turquoise, navy, teal, fuchsia, maroon.</i></p> <p><i>Examples of questions: Show me blue or Which picture is yellow?</i></p>
												<p>Cannot accurately identify at least 5 shapes.</p> <p><i>Shapes include: circle, square, triangle, rectangle, oval, heart, diamond, star, moon/crescent, cone, sphere, cube, cylinder, hexagon, trapezoid, parallelogram, pentagon, arrow, pyramid</i></p> <p><i>Examples of questions: Show me square, Where is the circle? or Point to the triangle.</i></p>
												<p>Cannot count 3 objects.</p> <p><i>Example: give me 3 blocks.</i></p> <p><input checked="" type="checkbox"/> Can only repeat counting when done by another person or TV show.</p> <p><input checked="" type="checkbox"/> Can count to three or even higher but does not know that numbers represent a certain quantity or things.</p>

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Cannot group objects by category.</p> <p><i>Examples: dogs and cats are animals, cars and trucks are vehicles, bananas and apples are fruit.</i></p>
												<p>Does not know common opposites (e.g., tall-short, more-less, hard-soft).</p> <p><i>Other examples include: in-out, rough-smooth, hot-cold, tall-short.</i></p>
												<p>Does not understand sequencing of events.</p> <p><i>Examples: hear a story and put pictures in order [running water – washing – drying] [mixing cake – baking cake – eating cake] [planting a seed – watering – growing plant].</i></p> <p><input checked="" type="checkbox"/> Can recite the alphabet or other memorized rote sequences but cannot sequence pictures from a story.</p>
												<p>Cannot name 10 colors.</p> <p><i>Colors include: red, green, blue, yellow, orange, purple/violet, brown, white, black, grey, pink, silver, gold, turquoise, navy, teal, fuchsia, maroon.</i></p> <p><input type="checkbox"/> Correctly answers “what color is this?” for ten different examples?</p>
												<p>Does not recognize their first and last name.</p> <p><input type="checkbox"/> Respond properly when asked “Will Pat Smith please stand up” or “Will Pat Jones please raise your hand?”</p> <p><input type="checkbox"/> Knows their own first and last name but cannot say them.</p>
												<p>Is two or more grade levels behind in two academic subjects.</p> <p><input checked="" type="checkbox"/> Parent report only, no documentation.</p>
												<p>Cannot tell time on a digital clock or watch.</p> <p><i>Can be either on a digital or analog clock or watch.</i></p> <p><input checked="" type="checkbox"/> Recites digits like an eye chart but does not really read the time.</p> <p><input type="checkbox"/> Able to read time but cannot relate time to their daily schedule.</p>

LEARNING

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Cannot identify coins by name.</p> <p><i>By name means penny, nickel, dime, quarter.</i></p> <p><input checked="" type="checkbox"/> Able to identify some but not all.</p> <p><input type="checkbox"/> Able to identify names of coins but not their value.</p>
												<p>Cannot provide primary phone number.</p> <p><input type="checkbox"/> Phone number is not memorized but child can provide it when asked by pulling out a piece of paper where it is written.</p>
												<p>Cannot provide primary address.</p> <p><i>Includes house number, street and city.</i></p> <p><input type="checkbox"/> Does not have address memorized but can provide it in written form.</p>
												<p>Cannot make change from a dollar.</p> <p><i>This question is trying to determine if a child understands that there is a relationship between coins and dollars. It is not intended to measure advanced math skills of actually determining change from a purchase in a store. It is intended to see if a child knows that certain coins in combination equal a dollar.</i></p> <p><input checked="" type="checkbox"/> Doesn't understand that four quarters equals one dollar.</p> <p><input checked="" type="checkbox"/> Has no concept that money has value.</p> <p><input type="checkbox"/> Cannot figure out how much change they should receive from a dollar for a purchase that cost \$.53.</p> <p><input type="checkbox"/> Knows that 10 dimes equals one dollar.</p>

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
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												<p>Requires supervision due to inability to problem solve routine issues.</p> <p><i>Example: if child missed their ride (bus, parent forgot to pick up after school) would the child know what to do?</i></p> <p><input checked="" type="checkbox"/> Cannot be left at home for long periods of time because the child will not know what to do if someone comes to the door or calls on the phone.</p> <p><input type="checkbox"/> The reason the child needs supervision is due to impulsivity or potential to participate in mischievous acts.</p>
												<p>Does not use time to follow a schedule.</p> <p><input checked="" type="checkbox"/> Cannot understand the passage of time.</p> <p><input checked="" type="checkbox"/> Does not relate time to activities throughout the day.</p> <p><input checked="" type="checkbox"/> Can recite the time but time has no meaning to them.</p> <p><input type="checkbox"/> Does not make good use of their time or procrastinates.</p>
												<p>Is three or more grade levels behind in two academic subjects.</p> <p><input checked="" type="checkbox"/> Parent report only, no documentation.</p>

6.18 Social Competency

Unlike many ADL/IADLs, Social Competency is a skill that continues to develop throughout childhood for all children. As a result, the questions contained in the CLTS FS that aim to measure delays in Social Competency require that the screener consider the child’s development to that of their same age peers. As children age, the skills required for social competency become much more sophisticated and subtle.

If a child is unable to develop the social skill due to a physical or communication or learning impairment, then they will demonstrate delays in social competency. If the item under Social Competency asks for the child’s ability to perform the subtle social act but the child in question cannot perform the primary social act, then select that item for the child. For example, one of the Social Competency questions asks, “Does not control his/her temper in disagreements with other children”. If the child does not have the ability to have disagreements with other children, then this is selected for them even though the question is designed to address the more advanced skill of controlling his/her temper.

6.18 Social Competency
 The ability to form relationships, interest in and skills needed to maintain positive relationships with adults and children, ability to understand the perspective and feelings of others, and skills needed to get along well in a group setting (for example, conflict resolution skills).

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not offer a social smile to immediate family. <i>A social smile occurs in response to a noise, something within baby's sight or another person's smile.</i></p> <input checked="" type="checkbox"/> Does not smile. <input checked="" type="checkbox"/> Only offers spontaneous smiles like those that happen while asleep, or when becoming awake, or while staring at the fabric pattern on a car seat. <input type="checkbox"/> Smiles in response to a noise, something in their sight or another person's smile.

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not calm down within a half an hour when soothed by a parent. <i>Unable to respond to comforting actions from familiar adults.</i></p> <p><input checked="" type="checkbox"/> Continues to cry for more than a half an hour after all efforts to meet the baby's needs have been exhausted.</p> <p><input type="checkbox"/> Cries frequently but calms after comforting (fed a bottle, changed a diaper, snuggled).</p>
												<p>Does not enjoy being picked up and held by family members. <i>Stiffens and arches his/her back when picked up.</i></p> <p><input checked="" type="checkbox"/> Reacts adversely to being touched by family members.</p> <p><input type="checkbox"/> Occasionally will resist being picked up or held by family members.</p> <p><input type="checkbox"/> Doesn't like one particular family member touching them.</p>
												<p>Does not demonstrate separation anxiety. <i>Does not become upset or cry when primary caregivers/parents leave.</i></p> <p><input checked="" type="checkbox"/> Is not concerned when his/her parents leave them in a <u>new</u> environment.</p> <p><input type="checkbox"/> No longer cries or becomes upset when parents leave because s/he has become accustomed to the setting (e.g., daycare).</p> <p><input type="checkbox"/> Cries or becomes upset when parents leave because s/he is emotionally attached to them.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not show an interest in what others around them are doing. <i>Ignores other people in his/her immediate environment.</i></p> <p><input checked="" type="checkbox"/> Interacts with people as if they were a piece of furniture. Doesn't show more interest in a person than they do for a refrigerator for example.</p> <p><input checked="" type="checkbox"/> Does not react to an adult trying to engage with them (e.g., being silly, playing with a toy near them, and offering to play a game).</p> <p><input type="checkbox"/> Is involved in an activity that holds their complete attention (such as TV) and does not notice when others enter the room.</p> <p><input type="checkbox"/> When given the opportunity to watch a toy or watch a person, generally child would rather watch other people.</p>
												<p>Does not want to play near or be with immediate family members. <i>Prefers to be alone rather than near those s/he trusts.</i></p> <p><input checked="" type="checkbox"/> Backs away from others or shows a preference to be alone.</p> <p><input type="checkbox"/> Won't actively play or interact with others but enjoys being near others.</p>
												<p>Does not play simple interactive games (e.g., So Big, Peek-a-Boo, Pat-a- Cake). <i>Does not respond to other's attempts to engage in playful exchange.</i></p> <p><i>To avoid cultural differences, this question is general to capture any type of interactive games played with young children.</i></p> <p><input checked="" type="checkbox"/> Regardless of encouragement from trusted adults, or other children, s/he will not play simple games.</p> <p><input type="checkbox"/> Plays some interactive games but doesn't like other ones.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not enjoy interacting with immediate family members. <i>Does not like family time looking at books, listening to songs, or rough and tumble play.</i></p> <input checked="" type="checkbox"/> Resists activities with family members and would rather be alone. <input type="checkbox"/> Is apprehensive about interacting with other children or familiar adults outside of their immediate family.
												<p>Does not like to be around other children. <i>Prefers to spend time alone even when other children are around.</i></p> <input checked="" type="checkbox"/> Typically chooses a space in a room with other children where s/he can be away from the other children. <input type="checkbox"/> Enjoys the opportunity to sit near or play in the vicinity of other children, although may not interact with the other children or parallel play. <input type="checkbox"/> Doesn't have opportunity to be around other children due to complex or fragile health condition.
												<p>Does not make sure his/her parents are nearby when exploring new places. <i>Approaches new environments without fear or caution.</i></p> <input checked="" type="checkbox"/> Investigates all new surroundings boldly without making sure his/her parents are around. <input type="checkbox"/> Checks in, at least visually, with a parent as they begin a journey into new places. <input type="checkbox"/> Doesn't continuously seek a parent during their exploration.

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not enjoy interacting with non-family members. <i>Would prefer to avoid trusted adults or children outside of his/her immediate family.</i></p> <p><input checked="" type="checkbox"/> Refuses to interact with familiar people outside of his/her immediate family. This may include neighbors, sitters, and extended family members like grandparents, cousins or others they do not live with.</p> <p><input type="checkbox"/> Doesn't interact with strangers.</p> <p><input type="checkbox"/> Willing to test the waters by interacting with people not in their immediate family.</p>
												<p>Does not show an interest in a variety of toys. <i>Does not enjoy playing with a number of toys designed for his/her developmental level.</i></p> <p><input checked="" type="checkbox"/> Shows interest in fans, lights, doors, etc in absence of playing with toys designed for their developmental level.</p> <p><input type="checkbox"/> Has a favorite toy that they prefer to play with but shows some interest in other toys as well.</p>
												<p>Does not parallel play with other children. <i>Is not comfortable playing with similar toys next to other children.</i></p> <p><input checked="" type="checkbox"/> Watches other children play from a distance but does not try to engage in similar activities near other children.</p> <p><input type="checkbox"/> Engages in cooperative play (e.g., building a block tower) with other children. This demonstrates a more advanced social skill.</p> <p><input type="checkbox"/> Doesn't have opportunity to be around other children due to complex or fragile health condition.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not assume different roles in play. <i>Does not engage in make believe or pretend play (e.g., pretends to play a mom, dad, cat or dog).</i></p> <p><input checked="" type="checkbox"/> Is not able to pretend to be someone/something other than themselves.</p> <p><input type="checkbox"/> Will pretend but doesn't want others to watch. Child can often be over heard playing make believe by themselves in their room.</p> <p><input type="checkbox"/> Is able to play make believe games but doesn't like to. Would prefer to play something else.</p> <p><input type="checkbox"/> Does not initiate pretend play but will participate if others are engaged in the activity.</p> <p><input type="checkbox"/> Does not engage in multiple roles but is able to pretend to be someone/something other than themselves.</p>
												<p>Does not play in group games with adult supervision. <i>Will not play games lead by trusted adults such as hokey pokey, circle games, or Simon says.</i></p> <p><input checked="" type="checkbox"/> Refuses to engage in group games even with adults directing the play.</p> <p><input type="checkbox"/> Demonstrates initial hesitation and watches for awhile before joining in.</p>
												<p>Does not take turns in play. <i>Does not share toys, or wait for his/her turn in a group game.</i></p> <p><input checked="" type="checkbox"/> Is unable to play games like duck-duck-goose because only one person is "it" and others have to wait their turn.</p> <p><input type="checkbox"/> Will not share their own toys but will share toys typically shared in group settings (e.g., shovels in the sandbox, swings on the playground).</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not insist on trying to do things independently. <i>Willingly allows others to help him/her in all activities throughout the day.</i></p> <p><input checked="" type="checkbox"/> Does not have the “me do” or “I can do it myself” attitude to activities that s/he has the physical ability to accomplish.</p> <p><input checked="" type="checkbox"/> Does one activity on their own but is unwilling to try to complete other activities independently.</p> <p><input type="checkbox"/> Has the attitude and willingness to do many activities of daily living throughout the day but doesn’t like to put away their toys or other activities that may be more like a chore.</p> <p><input type="checkbox"/> Has the interest in doing things for themselves but does not have the physical or cognitive ability to complete the task.</p> <p><input type="checkbox"/> Wants to do things by themselves, but gets frustrated to verge of tantrums when problems arise: paint that drips, paper airplane that will not fold right.</p>
												<p>Does not have an awareness of another child’s need for help or feelings. <i>Does not recognize when another child is happy, sad or hurt.</i></p> <p><input checked="" type="checkbox"/> Is oblivious to the feelings of others.</p> <p><input checked="" type="checkbox"/> Is not aware when another child needs help.</p> <p><input type="checkbox"/> Knows the other child needs help but doesn’t know what to do to meet that other child’s need.</p> <p><input type="checkbox"/> Can acknowledge the other child is happy, sad or hurt but doesn’t feel empathy for the child.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not identify one special friend. <i>Will play with anyone but does not have a best friend.</i></p> <p><input checked="" type="checkbox"/> Plays with anyone who will play with them but does not seek out a particular friend for whom they are more compatible.</p> <p><input checked="" type="checkbox"/> Does not have any friends.</p> <p><input type="checkbox"/> His/her best friend changes from week to week due to disagreements or any other reason. We are not measuring long term relationships.</p>
												<p>Does not participate in groups at play. <i>Prefer to play by himself/herself rather than be part of a group.</i></p> <p><input checked="" type="checkbox"/> When welcomed to join a group activity (e.g., game of tag, make believe games, building with blocks) chooses to play alone instead.</p> <p><input type="checkbox"/> Is not invited to join a group at play.</p> <p><input type="checkbox"/> Doesn't know how to ask permission to join a group or initiate a group activity with others.</p> <p><input type="checkbox"/> Doesn't have opportunity to be around groups due to complex or fragile health condition.</p>
												<p>Does not seek information or assistance from parents or teachers. <i>Does not ask for help (verbally or non-verbally) or seek information from a trusted adult.</i></p> <p><input checked="" type="checkbox"/> Does not ask teachers when s/he has a question or needs help.</p> <p><input type="checkbox"/> Is shy and needs encouragement to talk to adults other than parents or teachers but can ask his/her teacher questions in school.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not make transitions from one activity to another without disrupting others. <i>Unable to make transitions without having his/her discomfort affect others in the group.</i></p> <p><input checked="" type="checkbox"/> Cannot end an activity when it is time to move onto something else without making a scene and bothering others.</p> <p><input checked="" type="checkbox"/> Is provided extra time in their school day to make transitions when other children can be in separate space so this child does not disrupt the process for others. For example – leaves classroom 5 minutes early to go to another class or lunch so they are alone in the hallways because they would otherwise make it difficult for the other children to get to their next class on time.</p> <p><input type="checkbox"/> Doesn't like making a transition but does not have their disappointment affect others in the group.</p>
												<p>Does not question rules or punishments viewed as unfair. <i>Unable to express his/her sense of unfairness or simply doesn't care when things are unfair.</i></p> <p><input checked="" type="checkbox"/> Has no understanding of rules.</p> <p><input checked="" type="checkbox"/> Cannot tell someone that they believe that they were treated unfairly.</p> <p><input checked="" type="checkbox"/> Cannot challenge decisions pertaining to discipline, household rules, or societal rules such as homework must be done before watching TV, a set bed time, that certain kids are disciplined more at school than others or that girls may be treated differently than boys.</p> <p><input type="checkbox"/> Child gets upset when they don't win a game or get to go first and think that this is always unfair.</p> <p><input type="checkbox"/> Can tell their parent that their teacher has unfair rules but is not able to tell their teacher that they think the rules are unfair. Important skill is to be able to assert that they were wronged, not confront the person who made the rule.</p> <p><input type="checkbox"/> Even though their perception of wrong doing may be incorrect, they are able to express their sense of unfairness.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not control his/her temper in disagreements with other children. <i>Cannot disagree with peers without escalating into a temper tantrum or running away from the situation.</i></p> <p><input checked="" type="checkbox"/> Cannot express his/her own opposing view in disagreements with friends without losing control and either having a temper tantrum reaction that is inappropriate for their age or running away from the confrontation.</p> <p><input checked="" type="checkbox"/> Cannot engage in disagreements with their peers due to significant limitations in cognition or communication.</p> <p><input type="checkbox"/> Loses his/her temper on occasion when disagreeing with other children.</p> <p><input type="checkbox"/> Loses his/her temper in conflicts with parents.</p> <p><input type="checkbox"/> Can express conflicting opinions while managing his/her emotions in disagreements with peers.</p>
												<p>Does not maintain a friendship with at least one person. <i>Does not demonstrate the interpersonal give-and-take necessary to keep a friendship.</i></p> <p><input checked="" type="checkbox"/> Unable to have long term friendships because the moment s/he doesn't get his/her way, the friendship is over.</p> <p><input checked="" type="checkbox"/> Has only superficial friendships with classmates but has not tested the waters of reciprocity with one particular friend. Could be due to cognitive or physical limitations.</p> <p><input type="checkbox"/> Has friends that they have known for a long time.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not express an interest in spending time with similar aged peers. <i>Isolates himself/herself from peers.</i></p> <input checked="" type="checkbox"/> Does not want to participate in activities with other children. <input checked="" type="checkbox"/> Only participates in activities because their parents make them and would rather be left alone. <input type="checkbox"/> Has an interest in participating in activities like after school programs, scouts, 4-H, sports, music groups or clubs.
												<p>Does not show concern for the feelings of friends. <i>Does not notice another person's feelings and offer care or comfort.</i></p> <p>Note: It is not enough to recognize the feelings of another person. This item requires that a child also know how to demonstrate the ability to offer care or comfort to another person.</p> <input checked="" type="checkbox"/> Does not recognize that a peer's feelings have been hurt. <input checked="" type="checkbox"/> Can identify that someone else's feelings have been hurt but doesn't know what to do to provide comfort. <input type="checkbox"/> Can identify that someone else's feelings have been hurt but doesn't know what to do to provide comfort because they were the person who caused the hurt feelings in the first place. <input type="checkbox"/> Demonstrates concern for other's when their feelings are hurt but the effort s/he makes doesn't result in the other person feeling happy again.

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	
												<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Is not self confident in social situations. <i>Is not comfortable enough to express his/her opinion in everyday peer interactions.</i></p> <input checked="" type="checkbox"/> Unable to express his/her own view in conversations with friends. <input checked="" type="checkbox"/> Does not have the cognitive or communication skills necessary to engage in this type of conversation. <input type="checkbox"/> Is comfortable expressing his/her opinion with peers who have a similar disability but not with the general population. <input type="checkbox"/> Is able to assert his/her opinions in their own social circle but not in large or unfamiliar groups. <input type="checkbox"/> Is socially assertive and takes the initiative in social situations.
												<p>Does not assert social autonomy from parents. <i>Does not make decisions about interests, activities or ideas independent from his/her parents.</i></p> <input checked="" type="checkbox"/> Unable to make decisions affecting his/her own daily life. <input checked="" type="checkbox"/> Completely dependent on parents to make all decisions for them. <input type="checkbox"/> Able to make and follow through with his/her own decisions, live by his/her own set of rules about right and wrong and be less emotionally dependent on their parents. <input type="checkbox"/> Consults with parents to help make decisions but ultimately makes final decision for themselves.

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Repeatedly does not avoid situations that are likely to result in trouble. <i>Gets involved in situations that have caused trouble in the past or does not avoid peer pressure in going along with a bad idea.</i></p> <p><input checked="" type="checkbox"/> Has received correction or redirection to avoid dangerous or risky situations but continues to participate again and again.</p> <p><input checked="" type="checkbox"/> Demonstrates excessive familiarity with strangers.</p> <p><input checked="" type="checkbox"/> Unable to resist going along with a peer group even though they know the activity is dangerous or risky and should be avoided.</p> <p><input type="checkbox"/> Able to avoid peer pressure by giving a reason why it is a bad idea to go along, making an excuse as to why s/he can't participate, simply saying no, suggesting an alternative activity or just leaving the situation all together.</p>
												<p>Does not show respect for other people. <i>Does not get along with a variety of people, use pro-social manners, and show gratitude towards others.</i></p> <p><input checked="" type="checkbox"/> Unable to interact positively with others except for those in their own specific cultural group.</p> <p><input type="checkbox"/> Able to demonstrate basic acts of kindness towards others. This includes but is not limited to saying please and thank you.</p> <p><input type="checkbox"/> Able to interact positively with people who have different values and opinions than his/her own.</p> <p><input type="checkbox"/> Able to interact positively with children and adults with special needs or from different ethnic groups.</p>

SOCIAL COMPETENCY

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												<p>Does not demonstrate the capacity for intimacy with another. <i>Has not established close relationships that are open, honest, caring and trusting.</i></p> <p><input checked="" type="checkbox"/> Unable to establish same-sex friendships that involve being open, honest, caring and trusting.</p> <p><input type="checkbox"/> Has close same-sex friendships but does not have a romantic relationship with anyone.</p>
												<p>Does not avoid situations that may get him/her into trouble. <i>Makes unhealthy and unsafe decisions concerning drinking alcohol, using drugs, safe driving, safer sex, use of the internet, and other comparable situations.</i></p> <p><input checked="" type="checkbox"/> Repeatedly makes poor choices in situations that may cause harm to him/herself or others.</p> <p><input type="checkbox"/> Smokes cigarettes, although it is considered unhealthy and may get them into trouble.</p> <p><input type="checkbox"/> Has a legal guardian due to a severe cognitive impairment.</p> <p><input type="checkbox"/> Has experimented with unsafe situations but does not persist in them.</p> <p><input type="checkbox"/> Has made some mistakes along the way but in general makes healthy and safe decisions.</p>

SOCIAL COMPETENCY

6.19 Meal Preparation

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Needs help making simple meals for self.

6.20 Money Management

0-6 mos	6-12 mos	12-18 mos	18-24 mos	24-36 mos	36 mos-4 yrs	4-6 yrs	6-9 yrs	9-12 yrs	12-14 yrs	14-18 yrs	18 yrs +	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
												Needs help with managing money.

**MEAL PREP &
MONEY MGT**

6.21 Duration of Needs

***Is at least one of the _____ functional impairments checked expected to last for at least one year from the date of screening?**

For functional eligibility for long-term support programs, the child's need for help (i.e., her functional impairments) must be long-term. For every ADL/IADL item checked, screeners are asked to indicate whether the functional impairment(s) are expected to last for at least one year from date of screening. Health care providers regularly make such predictions. If some of the functional impairments are not expected to last but one or more is, then check "yes" for this question. If the screener is not clear about the duration, the screener can seek additional information. When the expected duration is not clear, the screener should check "Yes."

Please take your time answering these questions. It is imperative that screeners accurately record the duration of any specific functional limitation. On the ADL and IADL page, consider the specific check marks in each category (Bathing, Dressing, etc) and check that the limitation is expected to last if **any** of the items checked are expected to last a year from the date of screening.

***Example A:** Brandon a 5 year old child. Under Toileting the screener has checked both Incontinent during the day and Needs physical help, step-by-step cues or a toileting schedule, consider if either one is going to last for a year. If Brandon is not likely to be incontinent for another full year, but will continue to need physical help in the bathroom, the screener would select "Yes" to the duration question because there is at least one impairment under toileting that is expected to last a year.*

If a child is nearing a change in age cohort (0-6 months, 6-12 months, 12-18 months, 18-24 months, 24-36 months, 3-4 years, 4-6 years, 6-9 years, 9-14 years, 14-18 years, 18+years) and it is likely that the child will master the task you have checked but will not be able to complete the tasks listed for the next age cohort within the year, then answer "Yes" to the duration question.

The screener should check "No" if the child has cancer, an illness or surgery that resulted in higher needs than normal. This is especially true if the child had typical functional skills before this acute episode.

***Example B:** Carlos is a 2-month old with congenital heart defects. He is expected to have surgery next month and is expected to recover and regain full functioning within three months after that. Carlos is not eligible for long-term support programs.*

MODULE #7: School and Work

7.1 School

Does the child's physical health or stamina level cause the child to miss over 50% of school or classes or to require home education?

Unlike most questions on the CLTS FS, this one focuses on **physical conditions** only. This question is needed for children with physical disabilities who might be able to do their ADLs/IADLs but are unable to participate in school due to their physical condition.

This includes children who go to school but miss more than half of their classes due to therapies, treatments, or rest periods needed due to their condition. This does not include children who are present at school but have difficulties participating as a result of medication side effects, such as sedation.

Home-schooling may be a choice unrelated to the child's condition. Screeners will need to ask whether the child is being home-schooled because their physical health or stamina makes them unable to attend school most of the time.

If the child is not currently in school because of summer vacation or school holiday, but the current condition is such that the child would miss 50% if school were in session, the screener would check yes.

If the child has not missed school, but has a new diagnosis or an increase in the child's health needs, that will most likely cause them to miss 50% because of their treatment or condition, the screener would check yes.

If for any reason the screener questions the reason for home schooling, follow up with a qualified medical professional or a public school to verify the child's physical health or stamina needs.

Does the child's emotional or behavioral needs result in the child having failing grades, repeated truancy and/or expulsion; suspension; and/or inability to conform to school or work schedule more than 50% of the time.

This question refers to the child's current situation or needs within the past 6 months. Do not check this for children who only need in-school supports for emotional or behavioral problems (that question is available on the Mental Health page). This is checked for the child who is in an alternative educational environment due to their emotional or behavioral needs. If a child can function well in a special school for children with emotional disorders but cannot function in a public school setting, screeners answer "yes" to this question.

Is child currently attending high school?

If the child is between grades at school (for example it is June and the child has finished eighth grade and will enter high school in the fall) the screener will enter the anticipated grade.

If the child is home schooled, consider the grade they would be in public school based on the child's age. Please include a statement in the note section if the child is home schooled.

For the purposes of the screen, ninth through twelfth grade are considered high school.

What year is the child expected to leave school?

For most children, this will be the anticipated graduation date. However, some children will graduate but not leave high school. In this situation the screener will use the anticipated date they will actually leave school. For many children this will be at age 21 years.

Transition related supports provided to the child

This question does not affect functional eligibility. It is included in the CLTS FS to help promote systems improvements for children age 14-18 and their parents. The screener will check services that have been identified for the child by their support team.

7.2 Employment

Current employment status

This question is mostly to assist with job-related systems improvements.

“Currently employed” means that the person has a job and is actually working (not on medical leave).

Need for assistance to work

Screeners may need to ask some questions to distinguish the person’s actual needs from services that may be provided.

Example: Sandy works in a sheltered workshop but really doesn’t need help more than once a week. Screener should check that help is needed weekly, even though staff is present every day.

MODULE #8: Health-Related Services

8.1 Overview of the Health-Related Services (HRS) Table

- The HRS Table assigns “weights” to each check box in complex ways.
- There are many ways to get a Level of Care (LOC); even though one task for a child is not on the table or the screener cannot check it, the child may get a LOC some other way.
- The screen logic can “see” if a child is unable to report problems, and for some HRS tasks, will assign heavier “weights” for that child. For example, a tracheostomy in a baby requires much more oversight than a tracheostomy in a healthy teenager who can report problems and get help if needed.
- **Medications** (except for intravenous ones) are absent from the HRS section. Of course giving and monitoring medications are very important, often life-saving, tasks for children. Because these tasks are almost universally done for **all** children, they are not helpful in distinguishing nursing-home eligible children from non-eligible ones. It is difficult to remove subjectivity between “important,” “dangerous,” “life-saving” medications from “routine” ones, and the line cannot be drawn between routes of administration.
- Similar issues arose with other tasks that may or may not make a child eligible. For example, therapies, therapy follow-through exercises, and wound and special skin care. They usually do not in themselves make a child Hospital or Nursing Home eligible. At times they can be so extensive and time-consuming that they would make a child Hospital or Nursing Home eligible. For now, the CLTS FS uses number of times per day as the objective criteria.

In summary, the HRS Table information may be partially addressed in another portion of the screen such as ADLs/IADLs where a screener feels they cannot fully describe a child. That is because the goal is to seek **accurate** results with the **briefest** possible screen. Information that could not objectively determine LOC was left out. Remember that responses to all questions on the Functional Screen for a child will be assessed **in total when calculating functional eligibility**.

Two children could have the same skilled nursing needs, but one might get a Nursing Home LOC and one not. That is because one did not have the **functional impairments** that are needed to be considered Nursing Home eligible.

Also, two children could have the same skilled nursing needs, but only one is expected to have those needs long-term, for more than six more months. The child with similar needs that are not expected to persist would not be eligible for **long-term support** programs.

8.2 Medical or Skilled Nursing Needs

This table lists conditions or tasks without frequency of help needed. There may be “fuzziness” in whether tasks take “One hour a day or less” or “More than 1 hr/day.” Ask a few additional questions to get as accurate an answer as possible. Brief sessions can be added up---for instance, 15 minutes 6 times a day = 90 minutes per day.

Medical or Skilled Nursing Needs (Check all that Apply)	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
Rehabilitation program for brain injury or coma – minimum 15 hours/week	<input checked="" type="checkbox"/> Child has comprehensive home rehabilitation program to address physical, social and psychological needs to follow recent discharge from a rehabilitation hospital. <input type="checkbox"/> Child has finished in-patient brain injury rehabilitation and is receiving therapies at home and/or school. <input type="checkbox"/> Child had a brain injury years ago and receives on-going therapies at home and school.
Unable to turn self in bed or reposition self in wheelchair	<input checked="" type="checkbox"/> Child has quadriplegia and cannot turn himself over in bed. (Would expect child to need help with ADLs as well.) <input checked="" type="checkbox"/> Child needs someone to reposition her in a wheelchair and in bed to prevent skin breakdown. <input type="checkbox"/> Child can reposition herself somewhat in a wheelchair and can turn herself in bed.
Recurrent Cancer	<input checked="" type="checkbox"/> “Recurrent cancer” is written in child’s records. <input checked="" type="checkbox"/> Parent can clearly state cancer is “recurrent,” or that cancer had gone away and has come back. <input checked="" type="checkbox"/> Child was in remission but now cancer is growing again regardless of how much time has passed. <input checked="" type="checkbox"/> Child completed chemotherapy last year, but the cancer has come back. <input checked="" type="checkbox"/> Child has had radiation therapy, but the cancer has spread to other parts of the body (“metastasized”). <input checked="" type="checkbox"/> A new kind of cancer has developed regardless of how much time has passed since the last cancer was treated. <input type="checkbox"/> Child is still in first series of treatment. <input type="checkbox"/> Screener is not sure whether cancer is “recurrent” or still in first round of treatment.

Medical or Skilled Nursing Needs (Check all that Apply)	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
Stage IV Cancer	<p>Stage IV (“four”) Cancer is particularly life threatening. Typically with Stage IV Cancer, chemotherapy or radiation treatment is provided to reduce pain and suffering rather than as an anticipated cure.</p> <input checked="" type="checkbox"/> Parents clearly state that MD told them the child has “Stage Four” cancer. <input checked="" type="checkbox"/> “Stage IV” is written in medical records. <input checked="" type="checkbox"/> A healthcare provider tells the screener that the child has Stage IV cancer. <input type="checkbox"/> Parent says child’s prognosis is poor, but has not heard of “Stage Four” and the screener does not see it in records.
Tracheostomy	<input checked="" type="checkbox"/> Child has a current tracheostomy (“breathing hole” through front of throat). <input type="checkbox"/> Child had a tracheostomy in the past that is now almost healed closed.
Ventilator (positive pressure)	<input checked="" type="checkbox"/> Child continually uses a mechanical volume ventilator—one that forces air into the lungs. <input checked="" type="checkbox"/> Child uses a mechanical volume ventilator only while sleeping. <input type="checkbox"/> Child uses “C-PAP” or “BI-PAP” (which provides extra pressure but does not force air into lungs).
PT, OT, OR SLP by therapist (does not include behavioral problems)	<input checked="" type="checkbox"/> Child receives PT (physical therapy), OT (occupational therapy), or SLP (speech language pathology) done by a licensed therapist or an appropriately supervised therapy aide. <input checked="" type="checkbox"/> Child receives PT (physical therapy), OT (occupational therapy), or SLP (speech language pathology) during the school year but not over the summer because it is not provided by the school at that time. <input checked="" type="checkbox"/> PT, OT, or SLP has been recommended at a specific frequency but child has not received it yet. <input type="checkbox"/> In-home autism program. <input type="checkbox"/> Behavioral therapies. <input type="checkbox"/> PT, OT, or SLP has been recommended by a physician but no evaluation of required frequency has been established. <input type="checkbox"/> Exercises done by someone other than a therapist or therapy aide. <input type="checkbox"/> Child sees a therapist less than once a month.

Medical or Skilled Nursing Needs (Check all that Apply)	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
	<p>“Less than 6 sessions/week” OR “6 or more sessions/week”</p> <ul style="list-style-type: none"> • Add all three therapy disciplines to count the number of sessions per week. • A joint therapy session (e.g., PT and OT together at same time) can be counted as two sessions. • Group therapy sessions can be counted as long as led by a qualified professional. • Therapy can be provided at any location - home, school, or clinic. • A session must be at least 15 minutes long to be counted.
PT, OT, SLP therapy follow-through: Exercises, sensory stim, stander, serial splinting/casting, braces, orthotics	<p>This item captures a mix of things, all of which should be established by a physician or licensed therapist. Follow the definitions provided below; do not add anything.</p> <p>“Exercises”</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Records indicate the exercises are “PT, OT, SLP therapy follow-through.” <input checked="" type="checkbox"/> Exercises are part of an individualized treatment plan developed from a therapist’s full assessment, and therapist(s) taught caregivers what to do. <input checked="" type="checkbox"/> Parents continue to do therapy exercises for their child, as instructed by therapists, although they and child no longer require therapy oversight at this time. <input type="checkbox"/> The exercises are general things like taking a walk or riding a bike. <p>“Sensory stimulation”</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A therapist has taught the family or school staff to do sensory stim for child with tactile sensitivity. <p>“Stander” (A special positioning device to place a child in an upright position for weight bearing)</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Child is put into a stander for 30 minutes a day at school. <input type="checkbox"/> Child has a stander but doesn’t use it anymore. <p>“Serial splinting or serial casting”</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Child’s parents are doing “serial splinting”—applying specially adjusted splints or bi-valved casts to progressively stretch the child’s muscles to prevent contractures and facilitate treatment

Medical or Skilled Nursing Needs (Check all that Apply)	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
	<input type="checkbox"/> Child has worn the same splints (e.g., AFOs, KAFOs) for months to prevent contractures. This is not “serial splinting.” <input type="checkbox"/> Child is in a total body cast. “Braces, orthotics” <input checked="" type="checkbox"/> Child is unable and parents/caregivers must apply braces or orthotics and monitor for skin and nerve involvement.
Wound, site care or special skin care	“Wound care” (<i>Wound care must be required on a daily basis</i>) <input checked="" type="checkbox"/> Child has special gel dressing (e.g., Una boot, algiderm, duoderm, etc.) that is changed every 7 days. <input checked="" type="checkbox"/> Parents are changing gauze dressings 2 or 3 times a day. <input checked="" type="checkbox"/> Mom changes dressings twice a day and nurse cleans wound once a week. <input type="checkbox"/> Mom is applying “Band-Aids.” “Site or Special skin care” (<i>Site care must be required on a daily basis</i>) <input checked="" type="checkbox"/> Child requires more than routine site care of an ostomy, catheter or central venous line (IV). <input checked="" type="checkbox"/> Child whose site is severely infected and requires daily dressing change to save the site. <input checked="" type="checkbox"/> Child has a rare and severe skin disease that creates open skin requiring medicine and wrapping. <input type="checkbox"/> Child receives lotions or ointments applied to intact skin.

8.3 Definitions for Particular Health-Related Services

See “8.4 Frequency of Help/Services Needed” for instructions on how to fill in the frequency rows on the HRS table.

<p>Medical or Skilled Nursing Need</p>	<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
<p>BOWEL or OSTOMY - Related <u>SKILLED</u> Tasks (Digital Stim, Changing Wafer, Irrigation) Does not include site care.</p>	<p><input checked="" type="checkbox"/> Mom reports that child receives one or more of the treatments listed in this row.</p> <p><input checked="" type="checkbox"/> Parents do “skilled” tasks include changing the wafer (which adheres to the skin and needs to be cut to proper size to avoid skin breakdown around the ostomy), and irrigations.</p> <p><input type="checkbox"/> Child receives suppositories, laxatives, or other medications.</p> <p><input type="checkbox"/> Child is on a “toileting schedule” but has none of tasks listed in the row.</p> <p><input type="checkbox"/> Someone empties the ostomy bag a few times a day. (This is not a skilled task.)</p> <p><input type="checkbox"/> Child has urinary ostomy from the bladder. (See Urinary Catheter row.)</p>
<p>DIALYSIS (hemodialysis or peritoneal, in home or at clinic)</p>	<p>Sometimes dialysis is only needed a few times; be sure to confirm the duration of over six months. Dialysis is usually every other day, or three days a week. That should be the frequency checked for this row; do not check higher frequencies for general monitoring of blood pressure, fluid and diet, etc.</p> <p><input checked="" type="checkbox"/> Child goes to a dialysis clinic every other day. (Check “4-7 days/week” frequency.)</p> <p><input checked="" type="checkbox"/> Home health nurse or parents administer “peritoneal dialysis” every night. (Check “2 or more times/day” frequency for hooking up and disconnecting the dialysis system.)</p> <p><input type="checkbox"/> Site care and dressings to the dialysis shunt (an IV-like line for access to blood vessels) is captured in the wound care row, not here.</p>
<p>IVs - peripheral or central lines - fluids, medications, transfusions. Does not include site care.</p>	<p><input checked="" type="checkbox"/> Child goes to outpatient hospital or clinic to receive IV treatments.</p> <p><input checked="" type="checkbox"/> Parent flushes child’s central line once a day.</p> <p><input checked="" type="checkbox"/> Child has a port that is accessed twice a week for chemotherapy.</p> <p><i>Definition: “flush.” If an IV does not have fluids dripping in, it needs a “flush” - a tiny injection of blood thinner to keep it from clotting closed.</i></p>

Medical or Skilled Nursing Need	<input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked. <input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.
OXYGEN and/or deep SUCTIONING – With Oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.	<input checked="" type="checkbox"/> “Deep” suctioning (down the back of the throat into the windpipe) is being done. <input checked="" type="checkbox"/> Child wears oxygen while napping and overnight. Parent needs to apply it. The child’s vital signs are assessed when applying and discontinuing oxygen supply. (Check 2 or more times/day box.) <input checked="" type="checkbox"/> Child gets short of breath easily, and needs someone to monitor for that and apply oxygen if she needs it. Over the past few months, she has needed oxygen on average more than half the days, and each day she needs it, it is several times each day. 2 or more times a day is the most accurate average frequency for her. <input checked="" type="checkbox"/> Baby is on oxygen and needs continual monitoring of it. (Check 2 or more times a day.) <input type="checkbox"/> “Oral” or pharyngeal suctioning (i.e., just in the mouth) is being done. <input type="checkbox"/> Bulb suctioning in infant’s nostrils. <input type="checkbox"/> The oxygen vendor’s trips (usually every few weeks) to provide new tanks.
RESPIRATORY TREATMENTS: Chest PT, C-PAP, Bi-PAP, IPPB treatments (does NOT include inhalers or nebulizers)	Use this row to record frequency for respiratory treatments such as “C-PAP” or “Bi-PAP” and chest physiotherapy and postural drainage. <input checked="" type="checkbox"/> Child receives chest PT and respiratory therapy from a respiratory therapist. <i>Definition: “Chest PT” is chest physiotherapy to help move mucous up out of the lungs. It includes someone clapping on the child’s back, or vests or machines that shake or tap on the torso.</i> <input checked="" type="checkbox"/> Parents and school aides do chest PT and postural drainage twice every day. <input checked="" type="checkbox"/> Child uses C-PAP or Bi-PAP during sleep times. <i>Definition: A small machine blows air into a facemask, creating extra pressure that keeps the airway and lung more open. The machine does not breathe for the child; it only creates a little extra pressure.</i> <input checked="" type="checkbox"/> Child receives IPPB treatments 1 to 4 times a day depending on her breathing status. On average over the past few months, she receives IPPB treatments twice a day. (Check 2 or more times/day box.) <i>Definition: IPPB treatments and nebulizers involve pouring a precise amount of liquid medicine into an aerosolizing machine.</i> <input type="checkbox"/> An adult administers hand-held inhalers or aerosols.

<p>Medical or Skilled Nursing Need</p>	<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
<p>TPN (Total Parenteral Nutrition) Does not include site care.</p>	<p><i>Definition: This is when the child gets all their nutrition through an IV (intravenous) line. (“Parenteral” means outside the gut.)</i></p> <p>The solution is extremely high in sugars, so there is high risk of infection and of dangerously abnormal blood sugars. TPN is always run via an IV pump for precisely controlled infusion rate. It requires close monitoring, so most of the time the screener would check the “2 or more times a day” column.</p> <p><input checked="" type="checkbox"/> Child cannot receive nutrition through intestinal system, and receives continual TPN. Check “2 or more times a day.”</p> <p><input type="checkbox"/> Child has continual IVs, which parent calls “sugar water,” but the IV bags contain clear fluid, parent has never heard of “TPN,” and child eats food. <i>This is IV fluid with just a little sugar, not complete nutrition; it is not TPN.</i></p>
<p>TUBE FEEDINGS Does not include site care</p>	<p><i>Definitions: NG (nasogastric) A feeding tube down the nose (or mouth) and esophagus to the stomach. NG tubes are now rare and are always temporary, due to risk of aspiration into lungs, discomfort in nose and throat, and skin breakdown of the nostrils.</i></p> <p><i>Definition: G-tube (gastrostomy) A feeding tube goes through the abdomen into the stomach.</i></p> <p><i>Definition: J-tube (jejunostomy) A feeding tube goes through the abdomen into the intestine just below the stomach.</i></p> <p><i>Definition: “Mickey” A special button apparatus to hold a G-tube in place.</i></p> <p>The screener does not need to separate out every single task if several are done at the same time. Instead, indicate the general number of times a day that the tube feeding is changed, started, and stopped. Do not include flushing the tubing after medication administration.</p> <p><input checked="" type="checkbox"/> Young child is on a continuous tube feeding. The skilled tasks (checking for proper placement, starting a new bag of feeding, running the pump, etc.) are most often done many times a day. Check the “2 or more times a day” column.</p> <p><input checked="" type="checkbox"/> Child is starting to eat, but receives an 8-hour tube feeding 2 or 3 times a week. Check 4 to 7 times/week column.</p> <p><input checked="" type="checkbox"/> Child can eat by mouth but receives needed hydration through her G-tube. Check frequency of tube feedings for liquids.</p> <p><input checked="" type="checkbox"/> Child can eat and the G-tube is being used only for medications. The only skilled task is changing the G-tube every 30 days or so. Check 1-3 times/month column.</p>

<p>Medical or Skilled Nursing Need</p>	<p><input checked="" type="checkbox"/> Indicates that the item on the functional screen should be checked.</p> <p><input type="checkbox"/> Indicates that the item on the functional screen should NOT be checked.</p>
	<p><input type="checkbox"/> Flushing the tubing after medication administration is not counted as a skilled task.</p>
<p>URINARY CATHETER-RELATED SKILLED TASKS (straight caths, irrigations, instilling meds). Does not include site care.</p>	<p><i>Definition: "Straight caths" or "Intermittent urinary catheterizations" are an "in & out" cathing, done usually every 4 to 8 hours.</i></p> <p>There is a special exception in this row. Formerly, urinary catheters were changed every 30 days. Now, newer materials allow some catheters to be changed only every 60 to 90 days. For this task only, the screener can check the "1 to 3 times/month" column if someone changes the catheter, regardless of whether it is 30, 60, or 90 days (or somewhere in between).</p> <p><input checked="" type="checkbox"/> Child has a continually indwelling catheter almost all of the time. Someone else empties the bag 3 times/day. The only skilled task is to change the catheter every 60 days. Check 1 to 3 times/month.</p> <p><input checked="" type="checkbox"/> Child has a urinary catheter overnight only. If overnight, putting it in and taking it out count as 2 separate tasks. Check 2 or more times/day.</p> <p><input checked="" type="checkbox"/> 10-year-old boy with Spina Bifida self-catheterizes to empty his bladder six times a day. He has good clean technique and no problems with his self-cathing. His parents need to keep an eye out for signs of a urinary tract infection and call the doctor if they occur. The 4 to 7 times a week frequency is most accurate.</p> <p><input checked="" type="checkbox"/> Child has a suprapubic catheter (through the skin into the bladder). Parents "irrigate" (flush) the catheter twice a day. Check 2 or more times/day column.</p> <p><input checked="" type="checkbox"/> 12-year-old boy with Spina Bifida and some learning delays "sort of knows" how to catheterize himself, but he often does not do it, and his technique is not clean enough. He does not watch for or report the symptoms of urinary tract infections. Because of these problems, an adult usually needs to talk him through his self-cathing step-by-step. "Skilled nursing help" does include step-by-step cueing. Check the "2 or more times a day" box.</p> <p><input type="checkbox"/> Routine "cath care" usually just soap and water as normal part of bathing.</p>

8.4 Frequency of Help/Services Needed

1. For each condition or task (each row) that applies to the child, the screener will check to indicate either that the child is *independent* with the task, OR that they need skilled nursing *help from others*.
2. If the child does need skilled nursing help from others, screeners must indicate the **frequency** at which that help is needed.

Precision is important, and screeners will need to consult with healthcare providers or other experts familiar with the child and his or her needs.

Child is INDEPENDENT in Managing a Health-Related Service

- A child is independent in turning the oxygen on and off, taking it on and off, checking their oxygen saturation level (if required), and changing water bottles and tubing (if required).
- School nurse oversees girl's self-injections due to school policy, but girl is completely **independent** with the task and with monitoring for problems.
- Girl knows how to check her blood sugars but usually will not unless an adult reminds her and watches her to make sure she does it.

If the child is not independent in managing a condition, place one checkmark in the column showing the most accurate frequency of "Skilled Nursing Help from Others."

Skilled Nursing Help from Others

The HRS Table looks for "Skilled Nursing Help from Others." "Skilled nursing" describes the task being done, but **not who is doing it**. Parents and other family members or school professionals are often taught to do highly skilled nursing tasks.

Some examples of situations where parents and others are trained to provide this type of care include: a mom managing a child's ventilator, a dad administering a child's IM (intramuscular) shots, and/or a Nurse's aides, school aide, or other direct care workers having been taught to do the skilled task for this child. The screen is not concerned about someone doing other "unskilled" tasks not precisely listed on the Functional Screen. Skilled nursing help includes step-by-step cueing.

Frequencies of Skilled Nursing Help

The column headings are:

- 1 to 3 times/ month
- 1 to 3 times/ week
- 4 to 7 times/ week
- 2 or more times a day

Indicate Frequency of Skilled TASKS, Not Duration of Condition

For conditions that are continually present (e.g., an indwelling urinary catheter), the checkmark should indicate the frequency of tasks related to the condition. When one condition involves more than one task, check the most frequent task with which help is needed from others. Oxygen

is often worn continually; screeners should find the frequency at which the child needs help from others with particular tasks related to the oxygen.

***Example:** Sara has an indwelling urinary (“Foley”) catheter in continually. The catheter is changed (by a nurse) every 30 days. Daily “cath care” is just soap and water as normal part of bathing and is not really considered a “health-related service” on the screen. No irrigations are needed. Sara also has a tracheostomy. Tasks related to this include having a nurse change the trach tube once every month, and a parent clean the trach site (“trach care”) twice a day. Screener places TWO checkmarks: 1) Urinary catheter-related skilled tasks at “1 to 3 times/Month” and 2) Tracheostomy Care at “1-2 times/day.”*

Averaging Frequencies

Because it is a screen for **long-term** supports, the screen cannot just take a “snapshot” of what the child is getting for treatments today or this week, unless those treatments are expected to last for months at that frequency.

The screener will encounter frequencies of treatments that do not fit the columns in this table. Options are limited for brevity. Here are some guidelines for rounding off or taking averages for differing frequencies:

- If the frequency of treatments varies **over weeks or months**, select the answer that seems closest to the **average** frequency of help needed.
- If the frequency of treatments varies **day to day**, select the answer that most accurately describes their needs on the **higher** frequency days.
- If something is done less than once every month, the screener will not check it on the HRS table. If a task is done “every month or two”: Ask how many times over the past 6 or 12 months. If that averages to almost once/month, check the “1 to 3 times/month” column.
- If the frequency of treatments averages to less than once a month, do not check it.

Multiple Frequencies of one Health-Related Service

There are often multiple frequencies for a single health-related service. As a rule of thumb, check the one with the highest frequency. For example, there will often be several skilled tasks for one IV, each at a different frequency. Check the one of **highest** frequency.

Expected Frequencies

If the child is expecting to encounter health-related services in the near future, it may be difficult to determine the average frequency of help/services needed. With some conditions an educated estimate can be made. For example, if a child is expected to get a central line very soon it might be hard to predict the frequency of skilled tasks. However, since most central lines need to be flushed once/day, that is a safe box to check.

8.5 Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more?

A child must need **long-term** support, not just short-term. Sometimes the duration of a child’s health-related needs may be challenging for screeners to discover. Health care professionals

routinely make predictions about health conditions and treatments and their expected duration. Hopefully they have explained this to the parents or it is documented somewhere.

Check “No” if:

- Child is likely to be independent with the task within the next 6 months.
- Child is going to need less assistance (changing to a different *frequency of intervention*) with that task.
- Child is expected to have surgery soon and to fully recover within several weeks after that.
- Child is in intensive care now but is expected to recover within a few weeks/months.
- Child is in a total body cast but it is expected to be removed and activity resumed in about three months.
- Child has a temporary ostomy that is expected to be repaired within three months.

Check ”Yes” if:

- The child currently has a **tracheostomy, central line, TPN** or is on a **ventilator**, which is **expected to be removed** in less than 6 months. The screener is to give the benefit of the doubt in case it takes longer than expected to wean the child from these life-sustaining treatments.
- Child is waiting for an organ transplant.
- Child is receiving PT, OT and ST through the school system and the IEP indicates the therapy will continue next year.

MODULE #9: Screen Time and Notes

9.1 Screen Completion Date

The screen completion date is the date when all sections were completed by the certified screener, not the date information is entered into the computer. Indicate the date on which all sections of the CLTS FS were complete. It may take more than one day to complete all sections, especially if a screener must wait for information from health care providers. It is acceptable for one person to enter the demographic information (module 2) and for the certified screener to complete the clinical entries (modules 3-10). However, all of the screen entry time should be combined and put under the certified screener's name.

9.2 Time to Complete Screen

Face-to-Face Contact with Child and Parent(s) or Guardian

This is the amount of time the screener spent face-to-face meeting with the child and/or their parent(s) or primary caregiver. Face-to-Face contact includes the entire time spent at a home visit with the immediate family even if the child is only seen for part of that visit. For example, if the screener is at the home for 1½ hours but the child was only present for the last 30 minutes, the screener would put 1 hour, 30 minutes under face-to-face contact.

Collateral Contacts

This is the amount of time the screener spent face-to-face meeting with collateral contacts (extended family members, teachers, therapists, health care providers, etc). And/or the amount of time the screener spent on the phone talking with collateral contacts. This includes phone conversations with the child's parent(s) or guardian. Do not include conversations with others who are present at a home visit. For example, if the screener is at the home visit and the child's teacher is also at the home visit, the entire time spent in the home is recorded as face-to-face contact not collateral contact.

Paper Work

This is the amount of time the screener spent doing paperwork and paper research to complete the CLTS FS. Phone contact with the parent or primary caregiver should be included in this category. This does not include intake preparation.

Travel Time

This is the amount of time the screener spent traveling to and from appointments associated with the gathering of information necessary to complete the CLTS FS.

- Write all times as hours and minutes rounded to the nearest 15 minutes.
- The CLTS FS application will sum them up for the total time.

9.3 Final Notes

This space is provided for the screener to enhance or support the items they have checked (or did not check) on the CLTS FS. Some screeners may use the note section to complete necessary requirements for individual programs (e.g., narrative assessment for Waivers). However, this is NOT the primary purpose of the note sections as they relate to the CLTS FS. The PRIMARY purpose or expectation is that notes will be made to strengthen and corroborate items checked on the screen. If notes are added to existing notes on a page, *the most current notes should always be at the top of the list*. If a screener does not agree with previous notes on a page, or those notes are no longer applicable for the child, notes from previous screens can be deleted. Notes are always saved on the original screen and can be found in the History Screens section. Notes are to be entered in the following format:

Date (**mm/dd/yy**): Comments... Screener initials / program affiliation

By adhering to this format, a screener's comments are securely written between the date of the note and their initials. This reduces the opportunity for other screeners to inadvertently add comments to someone else's notes. Screeners are responsible for the notes they create.

MODULE #10: Functional Eligibility Results

10.1 Information Available on the Eligibility Results Page

Once the screener has selected CALCULATE ELIGIBILITY a new screen will appear with important information. At the top of the page will be the following information that helps identify who produced this screen and when it was completed. Included is:

- Screen Begin Date
- Screener Name
- Screen Entered By
- Eligibility calculated by Agency

The page will then display the following chart:

Eligibility Program	Eligibility Results	Pending Results
Comprehensive Community Service		
Community Recovery Services		
Community Options Program		
Family Support Program		
Children's Waivers		
Katie Beckett Medicaid Program		
MH Wrap Around		

For **Comprehensive Community Service**, the following **Eligibility Results** are possible:

- Functionally eligible to need services
- Not functionally determined to need services

For **Community Recovery Services**, the following **Eligibility Results** are possible:

- Functionally eligible to need services
- Not functionally determined to need services

For the **Community Options Program**, the following **Eligibility Results** are possible:

- Functionally eligible
- Not functionally eligible
- Not eligible due to living situation
- For an individual of this age, refer to the adult functional screen

For the **Family Support Program**, the following **Eligibility Results** are possible:

- Functionally eligible
- Not functionally eligible
- Not eligible due to adjudicated delinquent status
- Not eligible due to living situation
- For individuals over 22 years, please contact BLTS

For the **Children's Waivers**, the following **Eligibility Results** are possible:

- Mental Health Target Group (Psych Hospital LOC)
- Physical Disability Target Group (Nursing Home LOC)
- Physical Disability Target Group (Hospital LOC)
- DD Target Group (ICF-MR/DD1 LOC)
- DD Target Group (ICF-MR/DD2 LOC)
- Not eligible due to living situation
- This screen should not be used for an individual of this age
- Not functionally eligible

Note: The Children's Waivers Functional Eligibility Results will list all the target groups for which the child meets the functional eligibility requirements. The decision of which specific target group to select for any particular child is the responsibility of the agency/county using the Children's Waivers.

For the **Katie Beckett Medicaid Program**, the following **Eligibility Results** are possible:

- Psychiatric Hospital Level of Care
- Hospital Level of Care
- Nursing Home Level of Care
- ICF-MR/DD1 Level of Care
- ICF-MR/DD2 Level of Care
- Functionally eligible but is in an ineligible living situation
- Not eligible due to age
- Not functionally eligible

For the **MH Wrap Around**, the following **Eligibility Results** are possible:

- Functionally eligible
- Not functionally eligible
- Not eligible due to age

Pending Results may include:

- Not eligible due to lack of U.S. Citizenship documentation and verification. Services cannot be provided through this program without required documentation.
- Pending U.S. Bureau of Citizenship and Immigration Services verification.
- Pending Identity verification.
- Requires a disability determination
- Living Situation
- Adjudicated Delinquent Status
- N/A
- None

If a CLTS FS indicates that there are Pending Results for a child's functional eligibility, then only when those issues are resolved can one determine that a child actually meets the functional eligibility requirement for that particular program. However, meeting the functional eligibility for a program does not automatically make the child eligible for that program because there may be additional criteria that must be met prior to program eligibility.

Two exceptions to Pending Results:

If a child has a pending result that reads, “Pending U.S. Bureau of Citizenship and Immigration Services verification” then the screener must indicate in the note section when this verification has been made. This pending result will continue to display on future screens for this child but with the accompanying note, screeners can proceed with service provision.

If a child has a pending result that reads, “Requires a disability determination” but the child is applying for a locally matched waiver slot, the application can proceed. This pending result will continue to display for state funded waiver requirements.

At the bottom of the page is the reminder that “**This does not include FINANCIAL eligibility.**” This is important to keep in mind because Financial Eligibility is of significant importance to certain programs.

10.2 What Do These Results Mean?

The results only indicate that the child meets (or does not meet) functional eligibility for certain programs. It does not mean that they meet program eligibility. Some programs have additional criteria including financial eligibility that need to be determined for program eligibility. The CLTS FS only determines functional eligibility.

If the functional eligibility is pending anything, than the child is not considered functionally eligible for that program until the pending issues are addressed. The Level of Care (LOC) or Target Group that the child will meet once the pending issues are addressed is listed so that plans for their eventual functional eligibility can be made accordingly.

10.3 Confirm the Functional Eligibility Results

Screeners, as knowledgeable professionals in the field who have met the child and reviewed valuable information about the child, are responsible for confirming that the results of the CLTS FS meet with their professional judgment. If the outcome is not what the screener expected, the screener should complete a thorough review of the screen. If the results are the same following this initial review, they should conduct an internal review with someone else from the same agency. If the results are still in question, the screener should contact the CLTS FS Clinical Advisor for assistance.

If the result is that the child is Not Functionally Eligible, the screener should always request an internal review by their agency/entity. Each agency/entity is responsible for screen/screener quality assurance at a local level. The CLTS FS Clinical Advisor may be consulted when specific questions arise but cannot verify eligibility results for any child.

Screeners **should not** attempt to change their answer choices on the screen to get the results they anticipated. If the screener finds that they unintentionally checked something incorrectly on the screen, they can use the EDIT button to make small changes to their answer choices and recalculate eligibility. If the CALCULATE ELIGIBILITY button is selected multiple times on a single

child, the screener will be asked by State Clinical Staff to provide an explanation for their repeated eligibility calculations.

10.4 Sharing Functional Eligibility Results with Others

Naturally the functional eligibility results are to be kept confidential. This page is not to be shared in total with a family. If requested, the screener can share the results for the program the family requested a screen for, but do not share the results for other programs.

If the screener sees from the results that the child has met the functional eligibility for another program, the screener can refer the family to that program. Screeners are not required to make such referrals. The CLTS FS does not determine program eligibility so being found functionally eligible for a program does not guarantee program eligibility. Screeners should never tell a family that they are eligible for any program other than the program the screener is offering.

10.5 Functional Eligibility Results Affecting Eligibility for Other Programs

The CLTS FS determines functional eligibility for multiple programs. Therefore, it may find children ineligible for multiple programs as well. When the functional eligibility results indicate that a child is no longer functionally eligible for a program that they are currently receiving services from, it is the screener's responsibility to inform that program of their results. For example, if a screener is completing a CLTS FS for the Family Support Program and the results indicate that the child is no longer eligible for the Katie Beckett Program, the Family Support Program has a responsibility to inform the Katie Beckett Program of this change immediately.

As long as the CLTS FS is completed accurately, it does not matter who completed it or which program it is being completed for. The functional eligibility results are binding for all programs listed. It is important that the CLTS FS be completed based on fact and not subjectively as the results impact many programs for which the child may be functionally eligible.

10.6 Completed CLTS Functional Screen Summary Reports

There are summary report options available for a completed individual CLTS FS. These reports can be viewed at the web site and can also be printed. The reports have been developed based on feedback from screeners and managers who operate the programs for which the CLTS FS determines functional eligibility. There are three (3) report formats to choose from. The three reports are titled:

- FS report w/eligibility
- Family FS report w/notes
- Family FS report

FS report w/eligibility

This report is a complete report of everything the screener entered in the CLTS Functional Screen. This is the report that is used to determine functional eligibility for various programs and is used internally for review of completed screens. This is the only report that displays the functional eligibility results.

Family FS report w/notes

This report is designed to be shared with parents. It does not include some of the sections found in the FS report w/eligibility. It does not include the Screen Time or Eligibility Results pages. It does include all the notes the screener entered on the most recent screen. This report can be shared with parents who request a copy of the completed screen.

Family FS report

This report is designed to be shared with parents. It does not include some of the sections found in the FS report w/eligibility. It does not include the Screen Time or Eligibility Results pages. In addition, it does not include any of the notes the screener entered. This report can be shared with parents who request a copy of the completed screen.

MODULE #11: Resources for Certified Screeners

11.1 CLTS Functional Screen Online Course

<http://mynursingce.son.wisc.edu/index.pl?id=677949>

To access the online course for employees seeking to become certified to complete the Children's Long Term Support Functional Screen, go to link above through the University of Wisconsin Madison School of Nursing.

Enter the **Access Code**: DHS1117LR. This code must be entered **EXACTLY** as listed (DHS in all caps, 1117 and LR (in all caps). If you need help accessing the course, contact the SOS Help Desk at 608/266-9198 or DHSSOSHelp@wisconsin.gov.

After successfully completing the online course, certified screeners will be asked to complete a short survey online. Once the survey is complete, there is an opportunity to view and print their certificate of achievement. A notification will be automatically sent to DHS announcing that you have completed the course requirements. Specific instructions for obtaining security clearance and access to the screen application will be made available to new certified screeners at this time.

11.2 Obtaining, Deleting or Changing Access for Certified Screeners

<https://fsia.wisconsin.gov/>

Whenever a change needs to be made to a screener's access to the functional screen, a formal request must be submitted. This form is available on the State of Wisconsin's Human Service System Gateway page, see link above.

Click on the link to 'FSIA – Request Access' and update the necessary information on the form and then follow the instructions on that page.

Restricting Access to the CLTS Functional Screen

When a screener leaves your agency and no longer has need to access the CLTS Functional Screen, the screen lead or supervisor is responsible for directing the DHS SOS Desk to delete the screener profile for that person. This is important to ensure the integrity and confidentiality of the personal data that is kept on the CLTS FS website. If a screener will be doing screens in a different county or agency, he/she should have his/her profile reactivated by the new employer.

Maintaining Access with a Change in Name of an Employee

When a screener changes their name for any reason, they will need to submit a Functional Screen Web Access Request form to update this information.

11.3 CLTS FS Listserv

<http://dhs.wisconsin.gov/LTCare/FunctionalScreen/signup.htm>

Once certified, screeners are strongly encouraged to sign up for the CLTS FS Listserv. The Listserv is the principle way in which DHS will notify you about changes being made to the CLTS Functional Screen, clinical instructions and other screen-related resources. DHS manages the list to make certain screeners do not get unnecessary emails. This is a primary tool for all certified screeners to stay current on the CLTS FS. All certified screeners are accountable to know the information provided through the Listserv whether or not they sign up for the Listserv.

To join/unsubscribe the Listserv:

Go to the Functional Screen Listserv website above. You will receive a confirmation email after your request is approved. You should either store this message on your computer or print a hard copy for future reference. You must have an individual email address to participate in the Listserv. Listserv owners may verify that new subscribers have a need to know the information shared by the Listserv. After your request is received, an email will be sent to the Listserv that you are a new subscriber. You will recognize emails that come from the Listserv because the subject line will always begin with the name of the Listserv (Example: [cltsfslst] Update Volume 7, Number 3).

11.4 DHS Website for the Functional Screen

<http://dhs.wisconsin.gov/ltcare/FunctionalScreen/#childrens>

Certified Screeners can find important information concerning the CLTS FS at this website. Information includes:

- Current Clinical Instructions,
- Diagnosis Cue Sheet,
- Paper Form of the CLTS FS,
- Age Specific Questions for ADL and IADLs,
- Links to available webcasts.

11.5 Clinical Advisor for the CLTS FS

becky.burns@wisconsin.gov

Becky Burns is the Clinical Advisor for the CLTS FS. She can be contacted regarding specific clinical questions on the CLTS FS. Contact the Clinical Advisor when the final functional eligibility result is not what the screener expected or anytime a screener has a question about the options available on the CLTS FS. Under no circumstance should the Clinical Advisor's name appear in any individual child's functional screen. Her recommendations are to the certified screener, not to the screen itself as she has not had the opportunity to meet the child in question.

11.6 DHS SOS Help Desk

DHSSOSHelp@wisconsin.gov

Phone: 608-266-9198

Screeners can receive technical assistance on the CLTS FS by contacting the SOS Help Desk. Technical assistance includes, but is not limited to, issues such as not being able to access the screen, changes in Social Security Numbers, finding two files for the same child in the CLTS FS database, etc.

11.7 Process for Transferring a Functional Screen

The CLTS FS improves access to long-term supports for families by reducing multiple applications and eligibility reviews in order to access long-term supports and services. In addition to the benefits of this simplification for families is the reduction of duplication of effort by professionals at the state and county level. Central to this process is the acceptance of another certified screener's results for a child. Each certified screener has specific security and access rights. Therefore, a transfer process is needed to provide access to a certified screener in a different agency with differing security access.

The functional screen is a protected health record under HIPAA (the Federal Health Insurance Portability and Accountability Act). Transferring screens between agencies must be done in compliance with federal confidentiality and security rules and requirements.

1) When requesting a screen be transferred:

- a) Obtain a legible release, which the individual, their guardian or power of attorney has signed and dated.
- b) Contact the transferring agency and request that they transfer the screen to your agency; indicate that you will send them a signed release. Provide the transferring agency with the **exact name of your agency as it appears in the CLTS FS application**. This is especially important if there is more than one agency in your county.
- c) Send the release to the transferring agency.
All releases for the Katie Beckett Program can be faxed to the attention of the Katie Beckett Program Assistant at 608-261-8884.

2) When transferring a screen:

- a) Ask the requesting agency to send you a signed release from the individual, their guardian or power of attorney.
- b) Obtain the signed release.
- c) Transfer the screen to the requesting agency. Be sure to confirm that you have selected:
 - a. The correct individual applicant;

- b. The correct screen type (such as the adult screen, children’s screen, mental health screen); and
 - c. The correct receiving agency from the drop-down list.
- d) Notify the requesting agency that you have transferred the screen.

Once a screen is transferred, it cannot be revoked. If a screener transfers a screen to the wrong agency, only the agency that received the screen can transfer it back to your agency. It is not acceptable to ask the agency that incorrectly received the transferred screen to forward or transfer the screen to the correct agency. The agency that incorrectly received the screen must transfer the screen back to the agency that originally transferred the screen.

For instructions on how to transfer a functional screen, refer to the technical assistance document on our website at: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/training.htm>. If you need help transferring a screen, contact the SOS Help Desk at:

SOS Help Desk
608/266-9198
DHSSOSHelp@wisconsin.gov

3) What the person receiving the functional screen will do:

The person receiving the screen must check that the correct child’s screen was transferred. Within a timely manner, the screener should meet the child and complete a screen.

a) INITIAL SCREEN

Complete an INITIAL SCREEN if the child is applying for a different program in the new county.

b) RESCREEN

Complete a RESCREEN if the child is continuing services within the same program in a different county.

11.8 Incomplete Screens

Incomplete Screens create multiple problems on the CLTS FS. By definition, an incomplete screen is a screen where functional eligibility has not been calculated. This error happens most often when a screener has used EDIT to update information on an existing screen and has not recalculated eligibility. It may seem to the screener that the updated information was not pertinent to functional eligibility but the screen may still require recalculation. Any time a screener enters information in the CLTS FS they must save that information by advancing to a new page and checking to see if “Eligibility” in the left hand navigation column continues to have a green check mark next to it. If there is no green check mark, then functional eligibility must be calculated again.

There are two other ways to know if a screen is complete or not. The first is to look on the “My Recent Screens” page. If there is a clock image next to “CLTS” in the same row as the child’s name, then that screen is incomplete. The other is to run the **Screen Summary at Agency Level** report to generate a list of all incomplete screens by a screener’s name.

11.9 Note Sections on the CLTS FS

Note sections are available on every page of the CLTS FS. This space is provided for the screener to enhance or support the items they have checked (or did not check) on each page. Some screeners may use the note section to complete necessary requirements for individual programs (e.g., narrative assessment for Waivers). However, this is NOT the primary purpose of the note sections as they relate to the CLTS FS. The PRIMARY purpose or expectation is that notes will be made to strengthen and corroborate items checked on the screen. If notes are added to existing notes on a page, *the most current notes should always be at the top of the list*. If a screener does not agree with previous notes on a page, or those notes are no longer applicable for the child, notes from previous screens can be deleted. Notes are always saved on the original screen and can be found in the History Screens section. Notes are to be entered in the following format:

Date (**mm/dd/yy**): NOTES... Screener initials / program affiliation

Example:

09/07/10: *Child demonstrated specific skills, etc. BB/KBC*

The following specific notes are expected on certain pages:

Diagnosis: Note any specific diagnosis the child may have that was found on the Diagnosis Cue Sheet.

Examples:

09/07/10: *Developmental Disability and Seizure Disorder have been checked per the Diagnosis Cue Sheet for a diagnosis of Cornelia De Lange Syndrome. BB/KBC*

09/07/10: *Metabolic Disorder has been checked per the Diagnosis Cue Sheet for a diagnosis of Sanfilippo Syndrome. BB/KBC*

Mental Health:

- Note all details regarding any check marks for specific Symptoms (Violence, Suicidality, Psychosis, and Anorexia/Bulimia).
- Note all specifics regarding any selection of Rare and Extreme Conditions.

Examples:

09/07/10: *Violence has been checked because the child took a knife to school last week and threatened to use it. The police were involved. BB/KBC*

09/07/10: *Psychosis was not checked although this child has many behaviors that resemble psychotic behaviors including reporting that they are hearing voices. The doctors are still determining the actual root of the problems. BB/KBC*

09/07/10: *Although this child continues to have a diagnosis of Anorexia, the symptoms are well managed and therefore Anorexia/Bulimia was not checked on this page. BB/KBC*

09/07/10: Child attempted suicide 2 months ago. They have recently been released from the hospital. BB/KBC

Behavior: Note a detailed description of any check marks for specific Behaviors, especially those which occur at a frequency of “1-3 times/week” or “more than 4 times/week” and anytime “Other” is checked.

Examples:

09/07/10: Child is going through a difficult transition and has run away every weekend often requiring police to help find her. She reports that she was going to a friend’s house or walking off steam but was found miles away from home often walking along the side of a highway. BB/KBC

09/07/10: Child is constantly yelling at his parents. Often saying he hates them and uses profanity daily. Verbal Abuse was not checked as his behavior did not meet the requirements of this item on the CLTS FS. BB/KBC

09/07/10: Child engages in head banging behavior on a daily basis. She wear a helmet to protect her head. She will strike her head on walls and floors. BB/KBC

When another person (e.g., another screener, hearing officer, parent or CLTS FS Clinical Advisor) looks at a screen you have completed, it should be clear from reading the brief notes, why certain questionable items have been checked (or not checked) on the screen. This does not mean that there needs to be a note made every time a check mark is made. The critical notes are those that address items on the screen that might be questioned by someone else reviewing the screen.

Examples of items that do *not* require notes:

- A child with Cerebral Palsy who has items checked on the ADL page.
- A child with Down Syndrome who has items checked on the IADL page.
- A child with Bipolar who has services checked on the Mental Health page.
- A child with Spinal Muscular Atrophy who has items checked on the HRS page.

Examples of items requiring notes:

- A 6 year old child who has Verbal Abuse checked on the Behavior page.
- A child with Down Syndrome who has Running Away checked on the Behavior page.
- A child with Depression who has Respiratory Treatments checked on the HRS page.
- Any child who has Violence checked on the Mental Health page.
- Any child who has Torture or Abuse of Animals “4 or more days each week” checked on the Behavior page.

11.10 Reports Available on the CLTS FS

Screen Summary at Agency Level

This report will generate a list that includes all of the following information:

Applicant's Name, Date of Birth, SSN, Screener's Name, Screen Completed Date, County of Residence, County of Responsibility, Screen Type (Initial or Annual) and Status (Complete or Incomplete).

Screeners can collect this data for a specific county, agency, screener, status (incomplete or complete) or archive status (active or archived). It can also be collected within a specific date range.

This report helps agencies monitor screens that are incomplete, when screeners are completing screens, the types of screens being completed among other factors.

Screen Time Report

This report will generate a list that includes all of the following information:

Screener's Name, Applicant's Name, Date of Birth, SSN, Screen Complete Date, Screen Type (Initial or Annual), Screen Time, Referral Date, Screen Begin Date, Days from Referral Date to Screen Begin Date, and Days from Screen Begin Date to Screen Completion. This report also computes total screen time for an agency and for each screener within an agency.

Screeners can collect this data for a specific county, agency, screener or archive status (active or archived). It can also be collected within a specific date range.

This report helps agencies monitor the amount of time it takes for screeners to complete the tasks involved in meeting an applicant and completing a functional screen.

Screener Summary at Agency Level

This report will generate a list that includes all of the following information:

Screener's Name, Certification Begin Date, Certification End Date, Screener Profile (Child Screener, Child Screens - View Only) and Status (Active, Inactive).

Screeners can collect this data for a specific county, agency, screener status (Active or Inactive) or screener profile (Child Screener, Child Screens - View Only). It can also be collected within a specific date range.

This report helps agencies monitor the status of their screeners. This is especially important when an employee leaves employment or assumes a different role in the functional screen process.