DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00367 (12/2021)

STATE OF WISCONSIN

FUNCTIONAL ELIGIBILITY SCREEN FOR CHILDREN'S LONG-TERM SUPPORT PROGRAMS

INSTRUCTIONS: All dates should be entered as mm/dd/yyyy.

INDIVIDUAL INFORMATION

Screen Information

Name — Screening Agency		Screen Begin Date
Name — Screener	Date of Referral	Screen Type (Check only one box) ☐ 01 Initial Screen ☐ 02 Rescreen

Referral Source (check only one option)

- ☐ Parent(s)
- ☐ Other Relative
- ☐ Guardian
- ☐ Self
- ☐ Audiologist
- ☐ Birth-to-3 Program
- ☐ Child Care Provider
- ☐ Child Protective Services
- ☐ Children with Special Health Care Needs
- ☐ CompassWisconsin: Threshold
- ☐ Foster Care
- ☐ Katie Beckett Program
- ☐ Hospital or Clinic
- ☐ Out-of-Home Setting
- ☐ Physician/Clinic
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Public Health
- ☐ School
- ☐ Social Worker
- ☐ Special Needs Adoption
- ☐ State Center
- ☐ Therapist — Physical, Occupational, or Speech
- ☐ Other — Please specify:

For which of the following programs is *this* Functional Screen being completed? (Check all that apply at this time)

- ☐ Comprehensive Community Service
- ☐ Community Recovery Services
- ☐ Children's Community Options Program
- ☐ Children's Long Term Support Waiver
- ☐ Katie Beckett Medicaid Program
- ☐ Mental Health Wrap Around

Child's Basic Information

Name — Applicant (First)	(Middle)	(Last)
Gender ☐ Male ☐ Female	Date of Birth	Social Security Number (###-##-####)

Address

City	State	Zip Code	Phone — Home
County/Tribe of Residence	County/Tribe of Responsibility		

LIVING SITUATION

Current Residence of the Child (Check only one option)

- ☐ With Parent(s)
- ☐ With Other Unpaid Family Member(s)
- ☐ With Legal Guardian
- ☐ Adult Family Home
- ☐ Alone (includes person living alone who receives in home services)
- ☐ Community Based Residential Facility (CBRF)
- ☐ Residential Care Centers for Children and Youth
- ☐ Group Homes for Children
- ☐ Foster Home
- ☐ Home/Apartment
- ☐ DD Center/State Institution for Intellectual Disabilities or ICF-IID
- ☐ Mental Health Institute/State Psychiatric Institution
- ☐ No permanent residence
- ☐ Kinship Care
- ☐ Shelter Care Facilities
- ☐ With Spouse/Partner
- ☐ Nursing Home (includes rehabilitation facility if licensed as a nursing home)
- ☐ Level 5 Exceptional Foster Home
- ☐ With Live-in Caregiver(s)
- ☐ With Non-relatives/Roommates
- ☐ Other — specify:

If the child lives in a multiple bed complex, indicate the number of residents (# of beds) certified for: _____

If the child is in an out of home placement, is the child expected to return home within six months of screening date?

☐ Yes ☐ No

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 of age?

☐ Yes ☐ No ☐ 18 or older

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

☐ Yes ☐ No ☐ N/A

ETHNICITY AND RACE

Ethnicity — Is participant Hispanic or Latino? ☐ Yes ☐ No

Race [Optional] (Check all boxes that apply)

☐ American Indian or Alaska Native ☐ Black or African American ☐ White

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

INTERPRETER INFORMATION

If an interpreter is required, check language below (Check only one option)

☐ American Sign Language ☐ Hmong ☐ Other — Please specify:

☐ Spanish ☐ Russian

☐ Vietnamese ☐ A Native American Language

CONTACT INFORMATION

Contact Information 1

Contact Type (check only one option)
- ☐ Parent
- ☐ Non-Legally Responsible Relative
- ☐ Guardian of Person
- ☐ Other — Specify:

☐ Representative Payee

☐ Power of Attorney If Power of Attorney, check all applicable types
- ☐ POA Education ☐ POA Financial ☐ POA Health Care

Name — Contact (First)	(MI)	(Last)		
Address	City		State	Zip Code
Phone — Home	Phone — Work	Cell Phone		

Email

☐ **Has legal rights to child's records**

Best time to contact and/or comments

Contact Information 2

Contact Type (check only one option)
- ☐ Parent
- ☐ Non-Legally Responsible Relative
- ☐ Guardian of Person
- ☐ Other — Specify:

☐ Representative Payee

☐ Power of Attorney If Power of Attorney, check all applicable types
- ☐ POA Education ☐ POA Financial ☐ POA Health Care

Name — Contact (First)	(MI)	(Last)		
Address	City		State	Zip Code
Phone — Home	Phone — Work	Cell Phone		

☐ **Has legal rights to child's records**

Best time to contact and/or comments

Contact Information 3

Contact Type (check only one option)
- ☐ Parent
- ☐ Non-Legally Responsible Relative
- ☐ Guardian of Person
- ☐ Other — Specify:

☐ Representative Payee

☐ Power of Attorney If Power of Attorney, check all applicable types
- ☐ POA Education ☐ POA Financial ☐ POA Health Care

Name — Contact (First)	(MI)	(Last)		
Address	City		State	Zip Code
Phone — Home	Phone — Work	Cell Phone		

☐ **Has legal rights to child's records**

Best time to contact and/or comments

DIAGNOSES

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

☐ Yes ☐ No ☐ Do not know

Transplanted Organ	Pending	Had on (mm/yyyy)	Transplanted Organ	Pending	Had on (mm/yyyy)
☐ Bone Marrow/Stem Cell	☐	/	☐ Liver	☐	/
☐ Heart	☐	/	☐ Lung	☐	/
☐ Intestine	☐	/	☐ Pancreas	☐	/
☐ Kidney	☐	/			

Child's Diagnoses — Check all that apply and indicate if it is a PRESENTING diagnosis

A **PRESENTING diagnosis** by definition is a diagnosis that resulted in the child having needs that can be addressed through long-term support services and will become the direct focus of a service plan for this child.

Diagnosis	Presenting diagnosis?	Diagnosis	Presenting diagnosis?
☐ Aicardi Syndrome	☐Yes ☐No	☐ Lissencephaly	☐Yes ☐No
☐ Angelman Syndrome	☐Yes ☐No	☐ Liver Disease (Hepatic Failure, Cirrhosis)	☐Yes ☐No
☐ Adjustment Disorder	☐Yes ☐No	☐ Maple Syrup Urine Disease	☐Yes ☐No
☐ Allergy	☐Yes ☐No	☐ Mental Health Diagnosis — Other — Specify: _____	☐Yes ☐No
☐ Anemia (e.g., Sickle Cell, Fanconi's)	☐Yes ☐No		
☐ Anorexia Nervosa, Bulimia, or Other Eating Disorder	☐Yes ☐No	☐ Metabolic Disorder	☐Yes ☐No
☐ Antisocial Personality Disorder	☐Yes ☐No	☐ Mood Disorder	☐Yes ☐No
☐ Anxiety Disorder	☐Yes ☐No	☐ Multiple Sclerosis or ALS	☐Yes ☐No
☐ Arthritis	☐Yes ☐No	☐ Muscular Dystrophy	☐Yes ☐No
☐ Asperger's Syndrome	☐Yes ☐No	☐ Muskuloskeletal Disorder	☐Yes ☐No
☐ Asthma	☐Yes ☐No	☐ Neuromuscular Disorder	☐Yes ☐No
☐ Attention-Deficit Disorder, Attention-Deficit Hyperactivity Disorder	☐Yes ☐No	☐ Nutritional Imbalance (e.g., malnutrition, vitamin deficiency)	☐Yes ☐No
☐ Autism or Autism Spectrum	☐Yes ☐No	☐ Obsessive-Compulsive Disorder	☐Yes ☐No
☐ Bipolar Disorder	☐Yes ☐No	☐ Oppositional Defiant Disorder	☐Yes ☐No
☐ Blind or Severely Visually Impaired	☐Yes ☐No	☐ Osteogenesis Imperfecta ☐ Type 1 ☐ Type 2 or greater	☐Yes ☐No
☐ Brain Disorder (other than seizures) or Brain Damage	☐Yes ☐No	☐ Pallister Killian Syndrome	☐Yes ☐No
☐ Brain Injury — Traumatic (per statutory definition of TBI) ☐ Moderate or Severe ☐ Other	☐Yes ☐No	☐ Paralysis other than Spinal Cord Injury	☐Yes ☐No
		☐ Paralysis—Spinal Cord Injury	☐Yes ☐No
		☐ Patau Sundrome/Trisomy 13	☐Yes ☐No
☐ Cancer	☐Yes ☐No	☐ Peroxisomal Disorders	☐Yes ☐No
☐ Cardiac Condition	☐Yes ☐No	☐ Personality Disorder	☐Yes ☐No
☐ Cerebral Palsy ☐ Spastic Quadriplegia ☐ Other	☐Yes ☐No	☐ Pervasive Developmental Disorder	☐Yes ☐No
		☐ Phocomelia	☐Yes ☐No
☐ Cerebral Vascular Accident (CVA) (pre- or postnatal) ☐ Intraventricular Hemorrhage, grade III or IV ☐ Other	☐Yes ☐No	☐ Pica	☐Yes ☐No
		☐ Pitt-Hopkins Syndrome	☐Yes ☐No
		☐ Polydipsia	☐Yes ☐No
		☐ Post-Traumatic Stress or Acute Stress Disorder	☐Yes ☐No

☐ CHARGE Syndrome	☐Yes ☐No	☐ Prader-Willi Syndrome	☐Yes ☐No
☐ Cognitive Disability	☐Yes ☐No	☐ Prematurity/Low Birth Weight	☐Yes ☐No
☐ Conduct Disorder	☐Yes ☐No	☐ Reactive Attachment Disorder	☐Yes ☐No
☐ Congenital Abnormality	☐Yes ☐No	☐ Renal Failure or other Kidney Disease	☐Yes ☐No
☐ Contractures/Connective Tissue Disorder	☐Yes ☐No	☐ Respiratory Condition (other than asthma)	☐Yes ☐No
☐ Cornelia de Lange Syndrome	☐Yes ☐No	☐ Rett's Syndrome	☐Yes ☐No
☐ Cri-du-Chat Syndrome/5p deletion	☐Yes ☐No	☐ Rubenstein-Taybi Syndrome	☐Yes ☐No
☐ Cystic Fibrosis	☐Yes ☐No	☐ Schizoaffective Disorder	☐Yes ☐No
☐ Deaf or Severely Hearing Impaired	☐Yes ☐No	☐ Schizencephaly	☐Yes ☐No
☐ Dehydration/Fluid or Electrolyte Imbalance	☐Yes ☐No	☐ Schizophrenia or other Psychotic Disorder	☐Yes ☐No
☐ Depersonalization Disorder	☐Yes ☐No	☐ Seizure Disorder ☐ Infantile Spasms/West Syndrome ☐ Lennox Gastaut ☐ Uncontrolled Epilepsy ☐ Other	☐Yes ☐No
☐ Depression	☐Yes ☐No		
☐ Developmental Delay	☐Yes ☐No		
☐ DiGeorge Syndrome/22q11 deletion	☐Yes ☐No		
☐ Diabetes	☐Yes ☐No	☐ Sensory Disorder (other than Blind or Deaf)	☐Yes ☐No
☐ Digestive System Disorder (of mouth, esophagus, stomach, intestines, gall bladder, pancreas)	☐Yes ☐No	☐ Sexual and Gender Identity Disorder	☐Yes ☐No
		☐ Skin Disease	☐Yes ☐No
☐ Disruptive Behavior Disorder	☐Yes ☐No	☐ Smith-Lemli-Opitz Syndrome	☐Yes ☐No
☐ Dissociative Disorder	☐Yes ☐No	☐ Smith-Magenis	☐Yes ☐No
☐ Down Syndrome — Mosaic or Translocation	☐Yes ☐No	☐ Social Communication Disorder	☐Yes ☐No
☐ Down Syndrome — Trisomy 21	☐Yes ☐No	☐ Social Functioning Disorder	☐Yes ☐No
☐ Dysthymic Disorder	☐Yes ☐No	☐ Somatoform Disorder	☐Yes ☐No
☐ Edwards Syndrome/Trisomy 18	☐Yes ☐No	☐ Spina Bifida ☐ Myelomeningocele ☐ Other	☐Yes ☐No
☐ Endocrine Disorder (not Diabetes)	☐Yes ☐No		
☐ Failure to Thrive	☐Yes ☐No		
☐ Fetal Alcohol Syndrome/Effects	☐Yes ☐No	☐ Spinal Muscular Atrophy	☐Yes ☐No
☐ Fragile X Syndrome	☐Yes ☐No	☐ Spinocerebellar Ataxia Disorders	☐Yes ☐No
☐ Genetic/Chromosomal Disorder	☐Yes ☐No	☐ Stereotypic Movement Disorder	☐Yes ☐No
☐ Genitourinary System Disorder	☐Yes ☐No	☐ Storage Disorder (12 subtypes plus "Other" in dropdown list; reference FSIA or cue sheet for specific names)	☐Yes ☐No
☐ Hemimeagalencephaly	☐Yes ☐No		
☐ Hemophilia/Other Blood Disorder	☐Yes ☐No		
☐ Holoprosencephaly	☐Yes ☐No	☐ Substance Abuse Diagnosis — Other — Specify: _____	☐Yes ☐No
☐ Hypochondriasis or Body Dysmorphic Disorder	☐Yes ☐No		
☐ Hypoxic-Ischemic Encephalopathy ☐ Stage 2 or 3 ☐ Other	☐Yes ☐No	☐ Substance-Related Disorder, including Alcohol Abuse (not to include Caffeine or Nicotine Addictions)	☐Yes ☐No
☐ Immune Deficiency	☐Yes ☐No	☐ Tourette's Syndrome	☐Yes ☐No
☐ Impulse-Control Disorder	☐Yes ☐No	☐ Trauma Related Disorder	☐Yes ☐No
☐ Infection—Current or Recurrent Infection	☐Yes ☐No	☐ Trichotillomania	☐Yes ☐No
☐ Kabuki Syndrome	☐Yes ☐No	☐ Tuberous Sclerosis	☐Yes ☐No
☐ Koolen-de Vries Syndrome	☐Yes ☐No	☐ VACTERL	☐Yes ☐No
☐ Lesch-Nyhan Syndrome	☐Yes ☐No	☐ Wiedemann-Steiner Syndrome	☐Yes ☐No

☐ Limb Missing, Severe Limb Abnormality, Arthrogryposis	☐Yes ☐No	☐ Williams Syndrome	☐Yes ☐No
		☐ Wolf-Hirschhorn Syndrome/4p deletion	☐Yes ☐No
		☐ Wound, Burn, Bedsore, Pressure Ulcer	☐Yes ☐No

PRIMARY CARE PHYSICIAN INFORMATION

Does the child have a provider that meets most of his / her medical needs (primary care physician)?
☐ Yes ☐ No

If applicant has a primary care physician, please indicate type of provider:

☐ Adult Physician (internist, gynecologist, adult specialist)
☐ Family Practice Physician
☐ General Practice Physician
☐ Neurologist
☐ Nurse Practitioner
☐ Other Type of Physician — Specify:
☐ Oncologist
☐ Pediatric Specialist
☐ Pediatrician
☐ Physician's Assistant
☐ Psychiatrist

Notes (Include child's specific diagnoses for any general diagnostic category selected above.)

MENTAL HEALTH

Does the child need more than outpatient counseling to address their mental health or substance use disorder needs?

☐ Yes ☐ No

If the child has a clinical Mental Health diagnosis, 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 Mental Health diagnosis, is the disability expected to last one year or longer?

☐ Yes ☐ No

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

☐ Anorexia/Bulimia — Life threatening symptomology
☐ Psychosis — Serious mental illness with delusions, hallucinations, and / or lost contact with reality
☐ Suicidality — Suicide attempt in past 12 months or significant suicidal ideation or plan in past month
☐ Violence — Life threatening acts
☐ No symptoms apply

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

☐ Clinical Case Management and Service Coordination Across Systems
☐ Criminal Justice system
☐ Mental Health Services (Check all that apply):
  ☐ Psychiatric Medication checks with Psychiatrist or other Physician
  ☐ Counseling Sessions with Psychologist or Licensed Clinical Social Worker
  ☐ Inpatient Psychiatric Treatment
  ☐ Day Treatment — either partial or full day
  ☐ Behavioral Treatment for Children with Autism Spectrum Disorders under the supervision of a mental health professional
  ☐ In Home Psychotherapy under the supervision of a mental health professional
☐ Substance Abuse Services
☐ In-school supports for Emotional and/or Behavioral problems — Child has an Individualized Educational Plan (IEP) for Emotional/Behavioral Disorders (EBD) programming. Or the child has an active Behavioral Intervention Plan (BIP) in an IEP. Or the child requires informal supports for behavioral intervention on a regular basis.
☐ No services required

If the child currently receives or needs any of the above services, are supports, or would supports be more than three hours/week combined? ☐ Yes ☐ No

Does this child exhibit disruptive behaviors in structured settings on a daily basis that require redirection from an adult at a frequency of every three minutes or more often AND this behavior has been demonstrated consistently for the past six 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

Does this child experience nightmares or night terrors at least four times a week AND this sleep interruption has been consistent for the past six 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

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 six 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

Notes (Include notes if Anorexia, Bulimia, Psychosis, Suicidality or Violence have been selected above)

BEHAVIORS

****Current Intervention Reference Table**

Time-Out/Supervision	Medical/Professional Treatment	Emergency
• Regular time-outs • Restricted community access • Constant supervision ("in-line of sight")	• Professional medical treatment • Regular professional therapeutic treatment • Regular use of protective gear • Environmental Limitations • Constant supervision ("within arm's reach") • Interventions taught/recommended and used by parents/caretakers • Evidence based Interventions parents/caretakers have sought out and used	• Urgent or emergency medical treatment • Police involvement/Youth Justice involvement/Child Welfare • Intervention resulting in a temporary placement out of the home for intensive monitoring/treatment within the last six months

Child's Behavior (check all that apply)

Behavior	**Frequency** (over past 6 months)	**Current Intervention**** (see table above for information on options)	**Expected to Last 6 Months or More**?
High-Risk Behaviors			
Running Away	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Substance Abuse	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Dangerous Sexual Contact	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Use of Inhalants	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Self-Injurious Behaviors			
Head-Banging	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Cutting or Burning or Strangulating Oneself	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Biting Oneself Severely	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Tearing At or Out Body Parts	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No

	☐ 4 or more days each week		
Inserting Harmful Objects Into Body Orifices	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No

Behavior	**Frequency** (over past 6 months)	**Current Intervention**** (see table above for information on options)	**Expected to Last 6 Months or More**?
Aggressive or Offensive Behaviors			
Hitting, Biting, Kicking	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Masturbating in Public	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Inappropriate elimination: Urine, feces, or other bodily fluids (including spit or menstruation)	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Serious Threats of Violence	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Sexually Inappropriate Behavior Toward Children or Adults	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Abuse or Torture of Animals	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Lack of Behavioral Controls			
Destruction of Property / Vandalism	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Stealing, Burglary or Kleptomania within the Community	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No
Other (list): _____	☐ Never ☐ Less than once a month ☐ 1-3 days each month ☐ 1-3 days each week ☐ 4 or more days each week	☐ None ☐ Time-outs/Supervision ☐ Medical/Professional Treatment ☐ Emergency	☐ Yes ☐ No

☐ **None of the behavioral problems apply at this time.**

Notes (Describe specific behavior and intervention when one of the behaviors above has been selected)

ACTIVITIES OF DAILY LIVING (ADLS) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Refer to separate forms containing age-specific ADL and IADL questions.

SCHOOL AND WORK

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

☐ Yes ☐ No ☐ N/A

Does the child's behavior or emotional needs result in failing grades, repeated truancy and/or expulsion, suspension, and/or an inability to conform to school or work schedule more than 50 percent of the time?

☐ Yes ☐ No ☐ N/A

Is the child currently home schooled?

☐ Yes ☐ No ☐ N/A

Is the child currently attending high school?

☐ Yes ☐ No ☐ N/A

What year is the child expected to leave school?

Year (yyyy): _____

The following types of supports are expected for the child to prepare for leaving school (check all that apply)

☐ None
☐ Not known at this time
☐ Benefit Specialist
☐ Division of Vocational Rehabilitation (DVR)
☐ Other expected supports — Specify:
☐ Section 504 Plan
☐ Transition Individual Education Plan (TIEP)
☐ Transition Services from the County

Current Employment Status

☐ Not employed ☐ Employed full-time ☐ Employed part-time

Employment Interest

☐ Interested in a new job ☐ Not interested in a new job

If Employed, where? (check all that apply)

☐ Attends pre-vocational day/work activity program
☐ Attends sheltered workshop
☐ Has paid job in the community
☐ Works at home

Need for Assistance to Work

☐ Independent (with assistive devices if uses them)
☐ Needs help weekly or less (e.g., if problems arise)
☐ Needs help every day but does not need the continuous presence of another person
☐ Needs the continuous presence of another person

Notes:

HEALTH RELATED SERVICES

Medical or Skilled Nursing Needs (check all that apply):	Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more	
☐ Recurrent cancer / Date of Recurrence: _____ (mm/dd/yyyy)		
☐ Stage IV cancer / Date of Stage IV Diagnosis: _____ (mm/dd/yyyy)		
☐ Terminal condition (verified prognosis < 12 months)		
☐ Rehabilitation program for brain injury or coma — minimum 15 hours/week	☐ Yes	☐ No
☐ Unable to turn self in bed or reposition self in wheelchair	☐ Yes	☐ No
☐ Tracheostomy	☐ Yes	☐ No
☐ Ventilator (positive pressure)	☐ Yes	☐ No
☐ PT, OT, or SLP by therapist (does not include behavioral problems) ☐ Less than six sessions/week ☐ Six or more sessions/week	☐ Yes	☐ No
☐ PT, OT, or SLP therapy follow-through: exercise, sensory stim, stander, serial splinting/casting, braces, orthotics ☐ One hour a day or less ☐ More than one hour/day	☐ Yes	☐ No
☐ Wound, site care or special skin care ☐ One hour a day or less ☐ More than one hour/day	☐ Yes	☐ No

Place one checkmark per any row that applies

	Frequency of Help/Services Needed						Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more	
Health-Related Services Needed	N/A	In-depend	1-3 times / month	1-3 times / week	4-7 times / week	2 or more times / day		
BOWEL or OSTOMY related SKILLED tasks: digital stim, changing wafer, irrigation (does not include site care).							☐ Yes	☐ No
DIALYSIS: hemodialysis or peritoneal, in home or at clinic							☐ Yes	☐ No
IVs — peripheral or central lines: fluids, medications, infusion pumps related to Diabetic Care, and transfusions (does not include site care)							☐ Yes	☐ No
OXYGEN and/or deep SUCTIONING — with oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.							☐ Yes	☐ No
RESPIRATORY TREATMENTS: chest PT, C-PAP, Bi-PAP, IPPB treatments (does not include inhalers or nebulizers)							☐ Yes	☐ No
TPN (Total Parenteral Nutrition), does not include site care							☐ Yes	☐ No
TUBE FEEDINGS (does not include site care)							☐ Yes	☐ No
URINARY CATHETER-RELATED SKILLED TASKS: straight caths, irrigations, instilling meds (does not include site care)							☐ Yes	☐ No

Notes:

SCREEN COMPLETION TIME

Date of Screen Completion (mm/dd/yyyy): _____

Time to Complete Screen	Hours	Minutes
Face-to-face contact with the applicant		
Collateral Contacts		
Paper Work		
Travel Time		
Total Time to Complete Screen		

Screen Notes:
(Please use this format [MM/DD/YY: Comments. Initials/Program Affiliation]. Put most recent notes at the top.)

TRANSFER INFORMATION
To be completed after eligibility determination if applicant is referred to another program.

Date of Referral to Service Agency	Name — Service Agency