

**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) <input type="checkbox"/> 01 Initial Screen <input type="checkbox"/> 02 Rescreen

Referral Source (check only one option)

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

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

- | | |
|---|--|
| <input type="checkbox"/> Comprehensive Community Service | <input type="checkbox"/> Children's Long Term Support Waiver |
| <input type="checkbox"/> Community Recovery Services | <input type="checkbox"/> Katie Beckett Medicaid Program |
| <input type="checkbox"/> Children's Community Options Program | <input type="checkbox"/> Mental Health Wrap Around |

Child's Basic Information

Name – Applicant (First)		(Middle)	(Last)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> 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)

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

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 NA

CITIZENSHIP AND IDENTITY INFORMATION

U.S. Citizenship

Child has documentation to establish U.S. Citizenship—Verified by:

- | | |
|---|--|
| <input type="checkbox"/> U.S. Passport | <input type="checkbox"/> Certification of Report of Birth: DS-1350 |
| <input type="checkbox"/> Certificate of Naturalization: N-550 / N-570 | <input type="checkbox"/> Consular Report of Birth Abroad: FS-240 |
| <input type="checkbox"/> Certificate of Citizenship: N-560 / N-561 | <input type="checkbox"/> Certification of Birth Abroad: FS-545 |
| <input type="checkbox"/> SSI-MA Recipient—past or present | <input type="checkbox"/> Final Adoption Decree |
| <input type="checkbox"/> Medicare Recipient | <input type="checkbox"/> Medicaid Birth Claim |
| <input type="checkbox"/> SSDI Recipient | <input type="checkbox"/> Acquired citizenship through parents |
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Hospital Record |

Child does not have U.S. Citizenship but does have the following Alien Registration Number per the verified Permanent Resident Card: _____ (xxx-xxx-xxx).

Child claims to have U.S. Citizenship or an Alien Registration Number but required documentation was not provided.

Child is only seeking eligibility for the Children's Community Options Program, Comprehensive Community Services, and / or Mental Health Wrap Around Program.

Identity was Verified by:

- | | |
|--|---|
| <input type="checkbox"/> State or Territory Driver License | <input type="checkbox"/> ID issued by Federal, State, or local government |
| <input type="checkbox"/> School ID Card | <input type="checkbox"/> Medical Record |
| <input type="checkbox"/> School Records | <input type="checkbox"/> Institutional Care Affidavit: F-10175 |
| <input type="checkbox"/> Written Affidavit: F-10154 | <input type="checkbox"/> International driver's license |
| <input type="checkbox"/> Certificate of degree of Indian blood | <input type="checkbox"/> Employee photo ID card |
| <input type="checkbox"/> Certificate of degree of other U.S. American Indian | <input type="checkbox"/> Documentation pending |
| <input type="checkbox"/> Certificate of degree of Alaskan Native tribe | <input type="checkbox"/> Not a Medicaid Funded program |

ETHNICITY AND RACE

Ethnicity—Is participant Hispanic or Latino? Yes No

Race [Optional] (Check all boxes that apply)

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |

INTERPRETER INFORMATION

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

- | | | |
|---|---|--|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other—Please specify: |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Russian | |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> 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)
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Address	City	State	Zip Code
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Phone – Home	Phone – Work	Cell Phone
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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)
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Address	City	State	Zip Code
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Phone – Home	Phone – Work	Cell Phone
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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)
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Address	City	State	Zip Code
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Phone – Home	Phone – Work	Cell Phone
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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 Don't know

Transplanted Organ	Pending	Had on (mm/yyyy)	Transplanted Organ	Pending	Had on (mm/yyyy)
<input type="checkbox"/> Bone Marrow / Stem Cell	<input type="checkbox"/>	/	<input type="checkbox"/> Liver	<input type="checkbox"/>	/
<input type="checkbox"/> Heart	<input type="checkbox"/>	/	<input type="checkbox"/> Lung	<input type="checkbox"/>	/
<input type="checkbox"/> Intestine	<input type="checkbox"/>	/	<input type="checkbox"/> Pancreas	<input type="checkbox"/>	/
<input type="checkbox"/> Kidney	<input type="checkbox"/>	/			

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?
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Impulse-Control Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Infection—Current or Recurrent Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anemia (e.g., Sickle Cell, Fanconi's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Limb Missing, Severe Limb Abnormality, Arthrogyrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anorexia Nervosa, Bulimia, or Other Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Liver Disease (Hepatic Failure, Cirrhosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Antisocial Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mental Health Diagnosis—Other—Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Metabolic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asperger's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Multiple Sclerosis or ALS	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Attention-Deficit Disorder, Attention-Deficit Hyperactivity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muskuloskeletal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Autism or Autism Spectrum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Nutritional Imbalance (e.g., malnutrition, vitamin deficiency)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blind or Severely Visually Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brain Disorder (other than seizures) or Brain Damage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Oppositional Defiant Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brain Injury—Traumatic (per statutory definition of TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis other than Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis—Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Vascular Accident (CVA) (pre- or postnatal)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pica	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cognitive Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Post-Traumatic Stress or Acute Stress Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Congenital Abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Contractures / Connective Tissue Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prematurity / Low Birth Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reactive Attachment Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deaf or Severely Hearing Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Renal Failure or other Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dehydration / Fluid or Electrolyte Imbalance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Respiratory Condition (other than asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depersonalization Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rett's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schizoaffective Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schizophrenia or other Psychotic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Digestive System Disorder (of mouth, esophagus, stomach, intestines, gall bladder, pancreas)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Disruptive Behavior Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sensory Disorder (other than Blind or Deaf)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sexual and Gender Identity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down Syndrome – Mosaic or Translocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Social Communication Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Social Functioning Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Somatoform Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down Syndrome – Trisomy 21	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dysthymic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spinal Muscular Atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Endocrine Disorder (not Diabetes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Stereotypic Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance Abuse Diagnosis—Other—Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Fetal Alcohol Syndrome / Effects	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Genetic / Chromosomal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance-Related Disorder, including Alcohol Abuse (not to include Caffeine or Nicotine Addictions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Genitourinary System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hemophilia / Other Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hypochondriasis or Body Dysmorphic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tourette's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Trauma Related Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Trichotillomania	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Immune Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tuberos Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Wound, Burn, Bedsore, Pressure Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Adult Physician (internist, gynecologist, adult specialist) | <input type="checkbox"/> Oncologist |
| <input type="checkbox"/> Family Practice Physician | <input type="checkbox"/> Pediatric Specialist |
| <input type="checkbox"/> General Practice Physician | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Other Type of Physician—Specify: | |

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 his / her mental health or substance use disorder needs?

Yes No

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 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 three 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 behavioral intervention on a regular basis to avoid harm to themselves or others.
 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
<ul style="list-style-type: none"> Regular time-outs Restricted community access Constant supervision (“in-line of sight”) 	<ul style="list-style-type: none"> Professional medical treatment Regular professional therapeutic treatment Regular use of protective gear Environmental restraints Constant supervision (“within arm’s reach”) 	<ul style="list-style-type: none"> Urgent or emergency medical treatment Police involvement

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	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dangerous Sexual Contact	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Use of Inhalants	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-Injurious Behaviors			
Head-Banging	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cutting or Burning or Strangulating Oneself	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting Oneself Severely	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tearing At or Out Body Parts	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inserting Harmful Objects Into Body Orifices	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masturbating in Public	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinating on Another or Smearing Feces	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serious Threats of Violence	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually Inappropriate Behavior Toward Children or Adults	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abuse or Torture of Animals	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lack of Behavioral Controls			
Destruction of Property / Vandalism	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stealing, Burglary or Kleptomania within the Community	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (list): _____	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 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 NA

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 NA

Is the child currently home schooled?

Yes No NA

Is the child currently attending high school?

Yes No NA

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)

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Section 504 Plan |
| <input type="checkbox"/> Not known at this time | <input type="checkbox"/> Transition Individual Education Plan (TIEP) |
| <input type="checkbox"/> Benefit Specialist | <input type="checkbox"/> Transition Services from the County |
| <input type="checkbox"/> Division of Vocational Rehabilitation (DVR) | |
| <input type="checkbox"/> Other expected supports—Specify: | |

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)

- | | |
|---|--|
| <input type="checkbox"/> Attends pre-vocational day / work activity program | <input type="checkbox"/> Has paid job in the community |
| <input type="checkbox"/> Attends sheltered workshop | <input type="checkbox"/> Works at home |

Need for Assistance to Work (optional for unemployed persons)

- | | |
|--|---|
| <input type="checkbox"/> Independent (with assistive devices if uses them) | <input type="checkbox"/> Needs help every day but does not need the continuous presence of another person |
| <input type="checkbox"/> Needs help weekly or less (e.g., if problems arise) | <input type="checkbox"/> 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

<input type="checkbox"/> Recurrent cancer / Date of Recurrence: _____ (mm/dd/yyyy)	
<input type="checkbox"/> Stage IV cancer / Date of Stage IV Diagnosis: _____ (mm/dd/yyyy)	
<input type="checkbox"/> Terminal condition (verified prognosis < 12 months)	
<input type="checkbox"/> Rehabilitation program for brain injury or coma—minimum 15 hours / week	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unable to turn self in bed or reposition self in wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ventilator (positive pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP by therapist (does not include behavioral problems) <input type="checkbox"/> Less than six sessions / week <input type="checkbox"/> Six or more sessions / week	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP therapy follow-through: exercise, sensory stim, stander, serial splinting / casting, braces, orthotics <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than one hour / day	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wound, site care or special skin care <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than one hour / day	<input type="checkbox"/> Yes <input type="checkbox"/> No

Place one checkmark per any row that applies

Health-Related Services Needed	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
	NA	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).							<input type="checkbox"/> Yes <input type="checkbox"/> No
DIALYSIS: hemodialysis or peritoneal, in home or at clinic							<input type="checkbox"/> Yes <input type="checkbox"/> No
IVs—peripheral or central lines: fluids, medications, and transfusions (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> No
OXYGEN and/or deep SUCTIONING— with oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.							<input type="checkbox"/> Yes <input type="checkbox"/> No
RESPIRATORY TREATMENTS: chest PT, C-PAP, Bi-PAP, IPPB treatments (does not include inhalers or nebulizers)							<input type="checkbox"/> Yes <input type="checkbox"/> No
TPN (Total Parenteral Nutrition), does not include site care							<input type="checkbox"/> Yes <input type="checkbox"/> No
TUBE FEEDINGS (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> No
URINARY CATHETER-RELATED SKILLED TASKS: straight caths, irrigations, instilling meds (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> 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
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