Clinical Instructions

Wisconsin’s
Functional Eligibility Screen

Children’s
Long-Term Supports

Wisconsin Department of Health Services
Division of Medicaid Services
Bureau of Children’s Services
Madison, WI
P-00936 (06/2018)
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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

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 on 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. The CLTS FS provides functional eligibility determinations for seven programmatic areas, four functional levels of care (explained below), and three target group designations 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).
- It determines functional eligibility for multiple long-term support programs.
- It determines multiple levels of care and target groups.
- 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 ongoing 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), and trend and aggregate data to determine if screen results remain consistent and reliable. These efforts ensure 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, and 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 provide statewide consistency in eligibility determinations.

- **Accuracy:** Functional eligibility determinations must be correct and must match current accurate decisions, in every instance.
- **Brevity:** The CLTS FS only determines functional eligibility as it relates to the level of care criteria associated with each program’s functional eligibility requirements. 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.
- **Inclusive:** 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
- Children’s Community Options Program
- Katie Beckett Medicaid TEFRA Program
- Medicaid Home and Community-Based Services Waiver
- Mental Health Wraparound Services

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 which of the four institutional equivalent levels of care requirements are met. The four institutional levels of care are:

- Hospital (HOS)
- Psychiatric Hospital (SED)
- Nursing Home (NH)
- Intermediate Care Facility for people with an Intellectual Disability = Developmental Disability (DD)

A level of care (LOC) is required for both the Medicaid Home and Community-Based Services Waiver 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 Waiver is determined.
The CLTS FS also provides a functional eligibility determination for the Children’s Community Options Program (CCOP), 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 LOC requirements and their knowledge of the child’s abilities, or if the screener has any screen completion questions, then the screener must contact the CLTS FS mailbox at DHS. This is critical to the accuracy and reliability of each individual functional screen.

If a young adult 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 to 22 years of age, the screener must 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, long-term care programs will only 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 CCOP. 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 CCOP.

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 waiver 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 DHS and long-term support programs using 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 by providing information for a 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. Parent(s) may refuse to provide needed information and may refuse to have a CLTS FS 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 effect on their functional eligibility or ineligibility for other programs. No screen should be completed without parental consent.

Screening agencies shall comply with confidentiality and Health Insurance Portability and Accountability Act (HIPAA) 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.

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 CCOP 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 a face-to-face meeting with the child being screened. This typically occurs with a parent present. 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 best 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 providing services to the child. The screener must always have a face-to-face meeting with the child, even if other informants are contacted for information.

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 CCOP 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 that whenever the condition of a child enrolled in a long-term support program substantially changes, the CLTS FS is 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, the screener reviews 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 (ADL), 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 used.

**Screeners must adhere, at a minimum, to the following guidelines:**

- Screeners must read and closely follow screen definitions and instructions. 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.
- Screeners must address each question carefully to assure accuracy, even when a screener knows a child well.
- Screeners must 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.
- Screeners are prohibited from altering 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 email box must be contacted.
- Screeners are expected to refer all questions and concerns to the CLTS FS email box. 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 using the CLTS FS. This information may also lead to revisions in the CLTS FS to ensure ongoing quality improvement.

### 1.7 Requirements for Quality Assurance and Screener Qualifications

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 ongoing 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.

**A. 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 email box can address questions that arise as
a screener completes an individual child’s CLTS FS. Screeners should contact the CLTS FS email box whenever they obtain a different result than expected for a child based on the requirements of the LOC criteria. This includes functional eligibility and noneligible 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.**

**B. 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 FS for accuracy and consistency on an ongoing, 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.
- Emailing the CLTS FS email box regarding any screen results or inaccuracies discovered through these activities.

**C. State-Level Quality Assurance Review.** DHS reviews screens and uses 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:
- Different people will describe a child’s abilities, needs, and problems very differently.
- People often provide different information at different times or to different screeners.
- People may observe different functional abilities and needs over time or across different settings (such as 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 Related to the Child’s Needs

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 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. Each screener must gather as much information and 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. 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 and other caregivers or professionals.

In summary, screeners should follow this three-step process:
1. Ask more questions and rely on professional 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, other family members, teachers, therapists, physicians, and others who interact with the child in a variety of settings.
3. Ask, “Given all this information, what would other screeners choose for an answer?”

Screeners should include detailed notes to explain selections made on the screen when choosing an appropriate response is challenging or when presented with inconsistent information. As an example, if the parents of a child who has difficulty walking and transferring himself tell you he bathes himself, then the screener would follow the three-step process above and take detailed notes.

1. **Ask more questions:** Ask the parents and child how he bathes (for example, in the bathtub, the shower, or a sponge bath). Ask to look at the child’s bathroom to check for accessibility and adaptive equipment. Ask the parents and child how he gets in and out of the bathtub. If the bathtub has high sides, ask the child if he can lift his foot that high, and ask him to show you.

2. **Seek additional information from other people, such as the other parent, family members, teachers, therapists, or physicians:** They may have opinions as well as objective information (“He’s fallen at least four times in the bathroom,” or “He is embarrassed to ask for or accept help in the bathroom, even when he needs it.”)

3. **Use your professional judgment and ask, “Given all of this information, what would other screeners choose for an answer?”** Consider the responses given to all questions asked, and consider all of the information available. Based on all of the available information, a screener may determine that the child needs assistance with bathing.

If selecting the appropriate response on the screen is still challenging after following the three-step process and evaluating all of the available information, then discuss concerns with a supervisor who can assist in marking the screen appropriately or request guidance from the CLTS FS coordinator.
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, and then ask, “Given all this information, what would other screeners choose for an answer?”

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 professional 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, other family members, 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 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 is 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 Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (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 individuals with intellectual disabilities, a state center for developmental disabilities, or an institute for mental disorders, 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 health-related services (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. If the child’s condition or
situation changes from what was expected at the time the screen was initially completed, the
CLTS FS should be redone shortly after the child goes home.
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, 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, 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 SSN is when the child does not have an actual SSN issued at the time of the home visit (for example, 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 Master Customer Index (MCI) clearance. Therefore, if you have an 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 seven to 10 days to verify a child’s SSN. Other possible options are indications of a mismatch of information involving the child’s name, date of birth, and SSN.

**Social Security Number Entered Incorrectly**
When a screener identifies that an SSN has been entered incorrectly, the error must be corrected internally. Contact the DHS SOS Help Desk with the child’s full name, incorrect SSN, and correct SSN. 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 SSN. The screen with a pseudo or incorrect SSN 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 Search Function**
If the name of the child does not match as being assigned to your agency, then you will see the following (Fig. 1):
Select the button that reads “CREATE NEW.”

The “New Applicant” page will appear. Enter the child’s name, gender, date of birth (DOB) and SSN (Fig. 2).

Select “Next” after completing the fields in the “New Applicant” page. The page titled “MCI Clearance Results” may appear when a potential match is located in the database (Fig. 3):
On the MCI Clearance page potential matches for the child are displayed. Consider each and every potential applicant in this list.

In this example, there was one potential match with the name “Name M LName,” a slightly different date of birth (1/14/01 rather than 2/14/00), an SSN off by a few digits, the same gender, and “Yes” in the “Exists in FSIA” column. This represents an 82 percent match.

Notice that one of the columns in this table is labeled “Exists in FSIA.” FSIA stands for Functional Screen Information Access. If there is a YES in this column for a child, then it means there is a functional screen for that child that is currently “owned” by another agency.

It is critical to select “Use this Applicant” when the child is identified by name, DOB, or SSN, even when “Exists in FSIA” indicates “No.” It does not need to be a 100 percent match. Anything over an 80 percent match is good given the system’s limitations. If some of the information is inaccurate, then it can be updated or changed when entering the actual screen data. This is often the case for children who have had a change in their last name.

Another example (Fig. 4):
The MCI Clearance page for this example (Fig. 5):

![MCI Clearance Results](image)

In this example, there was one potential match with the name “FName LName,” who has the middle initial of M, the same date of birth, an SSN off by a few digits, the same gender, and “Yes” in the “Exists in FSIA” column. This represents a 90 percent match.

Once “Use this Applicant” is selected, the child’s name will appear on your list of “My Recent Screens.” Once the “CLTS” box is selected to the right of the child’s date of birth (under “Screen Categories”), it displays that a different agency “owns” the screen, and the screen needs to be transferred accordingly. Once the screen is transferred, it will display when performing the search.

If no other agency “owns” this screen, then enter the child’s information into the CLTS FS system for the first time.

### 2.3 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:

- The very first time a screen is created for a new applicant. No previous screen exists for the child.
- A child has a completed screen for one program but now is having their first screen completed for a different program.
• A child has been on a waiting list for a particular program and is now coming off the waiting list for service delivery.
• 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.

### 2.4 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 they 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.
2.5 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 automatically be 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 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.

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 the state-funded Children's Waiver 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 & Medicaid Services.

If this functional screen is being completed for a child applying for the 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 a waiting list and onto 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.”

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
- Community Options Program
- Children’s Community Options Program
- Children's Long-Term Support Waiver
- Katie Beckett Medicaid Program
- Mental Health Wrap Around

In order to accurately track screen quality by programs, this question provides an opportunity to indicate for which program(s) the screen is being completed. A child may apply for one program or multiple programs at a time. Once a child is receiving services through a program, the screener will only select that program when completing an annual Rescreen.

2.6 Child’s Information

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 P.O. Box, enter the street address and apartment information on line 1, enter the P.O. Box on line 2, and use the P.O. Box Zip code.

**County/Tribe of Residence and County/Tribe of Responsibility**
Select the appropriate county or 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 or tribe is responsible for services, costs, 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 overwritten if different counties are involved.

**2.7 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; and 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?”

**2.8 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.
2.9 U.S. Citizenship and Identity

Per federal regulations, U.S. 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 Waiver. COP and MH Wrap Around programs do not require citizenship and identity documentation. The CCS program requires participants to be Medicaid recipients prior to service provision, so U.S. citizenship and personal identity will have already been verified through their application to Medicaid.

For more information regarding these procedures, refer to the Acceptable Citizenship and ID Documentation list located at the end of this module.

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 nine-digit Alien Registration number. For cases with a nine-digit A number, all digits must be provided. For cases with an eight-digit A number, a zero (0) must be inserted before the eight digits.

☐ 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 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, as well as 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 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 CCOP, COP, MH Wrap Around, or 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 technical assistance lead for your county or your specific program manager.

2.10 Ethnicity and 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 American, 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 Asia, 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,” “Samoa,” 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.

2.11 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 people whose primary language is not English.

2.12 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 P.O. Box, enter street address and apartment information on line 1, P.O. Box on line 2, and use the P.O. 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.
ACCEPTABLE CITIZENSHIP AND ID DOCUMENTATION

- Level 1: Documentation documents both citizenship and identity.
- Levels 2, 3, and 4: Documentation documents only citizenship. It must be presented with documentation of identity (level 5).
- Levels 5: Documentation documents only identity. It must be presented with documentation of citizenship (levels 2, 3, or 4).
- Level 7: Documentation can be used to meet Citizenship or Identity.

**Level 1 Documentation of Citizenship and Identity**

<table>
<thead>
<tr>
<th>Doc Level</th>
<th>Acceptable Documentation</th>
<th>Valid CARES Code</th>
<th>Description/ Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U.S. Passport</td>
<td>PP</td>
<td>The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. Passports issued with a limitation may only be used as proof of identity.</td>
</tr>
<tr>
<td>1</td>
<td>Certificate of Naturalization</td>
<td>CI</td>
<td>Form N-550 or N-570. Issued by the Department of Homeland Security for naturalization.</td>
</tr>
<tr>
<td>1</td>
<td>Certificate of Citizenship</td>
<td>CI</td>
<td>Form N-560 or N-561. The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</td>
</tr>
<tr>
<td>1</td>
<td>State Data Exchange (SDX)</td>
<td>SC</td>
<td>The state has conducted a data match between SDX and individuals known to CARES, updating the citizenship verification field with the code “SC” whenever SDX indicated that an individual’s U.S. citizenship had been confirmed for SSI or Medicare purposes. SDX is considered primary evidence of U.S. citizenship, so individuals whose citizenship verification field contains SC are considered to have met both the citizenship and the identification documentation requirement. No further documentation should be required of such individuals.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
<td>Valid CARES Code</td>
<td>Description/ Explanation</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>1</td>
<td>SSI-Medicaid/ BadgerCare Plus Recipient Medicare Recipient SSDI Recipient</td>
<td>SC</td>
<td>Use the SC code when updating SSI-MA medical assistance, SSDI, and Medicare recipient records via the SDX indicator of citizenship. Verify the receipt of these benefits by completing an online query (SOLQ) of DXSX for SSI and DXSA for Medicare and SSDI. To confirm SSDI receipt on DXSA, the person must be in current pay status on their own account and under age 62. The SSA claim number is the person’s SSN and the BIC is “A.” Individuals receiving SSI-MA medical assistance, SSDI, or Medicare are exempt from this policy and should not be asked to provide citizenship or identity documentation.</td>
</tr>
<tr>
<td>1</td>
<td>Individual is a Continuously Eligible Newborn (CEN)</td>
<td>NB</td>
<td>Use the NB code when a CEN is being added to a case. Citizenship and identity verification is not required for CEN individuals until the next review is done. This code will automatically be removed from the fields at review or intake so that a valid code can be entered at that time.</td>
</tr>
</tbody>
</table>
**Levels 2-4 Documentation of Citizenship Only**

<table>
<thead>
<tr>
<th>Doc Level</th>
<th>Acceptable Documentation</th>
<th>Valid CARES Code</th>
<th>Description/ Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Birth Certificate</td>
<td>BC BQ</td>
<td>A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain’s Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously “issued”) by the state, commonwealth, territory, or local jurisdiction. It must been created/recorded before the person was 5 years of age. A delayed (previously “amended”) birth record document that is amended after 5 years of age is considered fourth-level evidence of citizenship. Use BQ if a birth record query is done. <strong>Note:</strong> Effective October 1, 2010, all Puerto Rican Birth Certificates issued before July 1, 2010, are invalid. Ongoing recipients of IM programs from Puerto Rico do not need to submit new, valid birth certificates. However, all Puerto Rican Birth Certificates submitted by applicants must have been issued after July 1, 2010.</td>
</tr>
<tr>
<td>2</td>
<td>Certification of Report of Birth</td>
<td>SD</td>
<td>The Department of State issues a DS-1350 to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.</td>
</tr>
<tr>
<td>2</td>
<td>Consular Report of Birth Abroad of a US Citizen</td>
<td>SD</td>
<td>Form FS -240. The Department of State consular office prepares and issues this. Children born outside the U.S. to U.S. military personnel usually have one of these.</td>
</tr>
<tr>
<td>2</td>
<td>Certification of Birth Abroad</td>
<td>SD</td>
<td>Form FS -545. Issued by the Department of State consulates prior to November 1, 1990.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
<td>Valid CARES Code</td>
<td>Description/ Explanation</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>U.S. Citizen ID Card, American Indian Card, or Northern Mariana Card</td>
<td>CD</td>
<td><strong>U.S. Citizen ID Card</strong>&lt;br&gt;The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>American Indian Card</strong>&lt;br&gt;Form I-872. DHS issues this card to identify a member of the Texas Band of Kickapoo living near the U.S./Mexican border. A classification code of “KIC” and a statement on the back denote U.S. citizenship.</td>
</tr>
<tr>
<td>2</td>
<td>Final Adoption Decree</td>
<td>AD</td>
<td>The adoption decree must show the child’s name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child’s name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of Civil Service Employment by U.S. Government</td>
<td>ER</td>
<td>The document must show employment by the U.S. government before June 1, 1976. Persons employed with the U.S. government prior to that date had to be U.S. citizens.</td>
</tr>
<tr>
<td>2</td>
<td>Official Military Record of Service</td>
<td>MS</td>
<td>The document must show a U.S. place of birth.</td>
</tr>
<tr>
<td>2</td>
<td>Medicaid Birth Claim</td>
<td>MB</td>
<td>When the Wisconsin Medicaid program pays the costs associated with the birth of an infant, the infant will be considered a U.S. citizen who has met the citizenship documentation requirement. Because this is level-two evidence of citizenship, the identity documentation requirement must still be met. This code was used by DHS when the appropriate automated data matching was done. This code can also be entered by workers when presented with the appropriate documentation.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
<td>Valid CARES Code</td>
<td>Description/ Explanation</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Individual who Previously Received Assistance Through Foster Care, Adoption Assistance or Katie Beckett</td>
<td>OP</td>
<td>Use this code when you are aware that an individual who previously received assistance through the Foster Care, Adoption Assistance, or the Katie Beckett Program has provided proof of their citizenship or identification through that program.</td>
</tr>
<tr>
<td>2</td>
<td>SAVE Database</td>
<td>SV</td>
<td>Use this code when using the SAVE system to verify citizenship status for noncitizens who gained U.S. citizenship.</td>
</tr>
<tr>
<td>2</td>
<td>Acquired Citizenship Through Parent(s) as Outlined in the Child Citizenship Act 2000 (CCA)</td>
<td>CA</td>
<td>IM workers can use this code when an individual demonstrates that they have gained their U.S. citizenship through the CCA.</td>
</tr>
<tr>
<td>3</td>
<td>Hospital Record</td>
<td>HR</td>
<td>Extract of a hospital record on hospital letterhead established at the time of the person’s birth that was created five years before the initial application date and that indicates a U.S. place of birth. Do not accept a souvenir “birth certificate” issued by the hospital. Note: For children under 16, the document must have been created near the time of birth or five years before the date of application.</td>
</tr>
<tr>
<td>3</td>
<td>Life, Health, or Other Insurance Record</td>
<td>IP</td>
<td>Must show a U.S. place of birth and have been created at least five years before the initial application date.</td>
</tr>
<tr>
<td>3</td>
<td>School Record</td>
<td>ED</td>
<td>The school record must show a U.S. birthplace, name of child, date of birth, date of admission to school, and name and place of birth of the applicant’s parents.</td>
</tr>
<tr>
<td>3</td>
<td>Religious Record or Baptismal Certificate</td>
<td>RR</td>
<td>An official religious record that is filed with a religious organization within three months of the birth. The document must show a U.S. birthplace and either the date of birth or the individual’s age at time the record was made.</td>
</tr>
<tr>
<td>4</td>
<td>State or Federal Census Record</td>
<td>CE</td>
<td>Must show birthplace, citizenship, and age. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, recipient, or state should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion: “U.S. citizenship data requested.” Also add that the purpose is for Medicaid eligibility. This form requires a fee.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
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</tr>
<tr>
<td>4</td>
<td>Seneca Indian Tribal Census Record or Bureau of Indian Affairs Census Records of the Navaho Indians</td>
<td>SN</td>
<td>Must show U.S. birthplace and have been created at least five years before the application for Medicaid.</td>
</tr>
<tr>
<td>4</td>
<td>Bureau of Indian Affairs Roll of Alaska Natives</td>
<td>IA</td>
<td>Must show U.S. birthplace and have been created at least five years before the application for Medicaid.</td>
</tr>
<tr>
<td>4</td>
<td>U.S. State Vital Statistics Official Notification of Birth Registration</td>
<td>VS</td>
<td>Must show a U.S. birthplace and have been created at least five years before the application for Medicaid.</td>
</tr>
<tr>
<td>4</td>
<td>U.S. Birth Record Amended More than Five Years After Person’s Birth</td>
<td>BR</td>
<td>Must show a U.S. birthplace and have been created at least five years before the application for Medicaid.</td>
</tr>
<tr>
<td>4</td>
<td>Signed Statement by Physician or Midwife in Attendance at Birth</td>
<td>DS</td>
<td>Must show a U.S. birthplace and have been created at least five years before the application for Medicaid.</td>
</tr>
<tr>
<td>4</td>
<td>Admission Papers from Nursing Home, Skilled Nursing Care Facility, or Other Institution</td>
<td>NH</td>
<td>Must show a U.S. birthplace and have been created at least five years before the application for Medicaid/BadgerCare Plus.</td>
</tr>
<tr>
<td>4</td>
<td>Medical Record (Doctor, Clinic, Hospital)</td>
<td>MD</td>
<td>Must show a U.S. birthplace and have been created at least five years before the application for Medicaid. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. Note: For children under 16, the document must have been created near the time of birth or five years before the date of application.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
<td>Valid CARES Code</td>
<td>Description/ Explanation</td>
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</tbody>
</table>
| 4         | Written Affidavit        | WA              | Used only in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:  
- There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant’s or recipient’s claim of citizenship (the two affidavits could be combined in a joint affidavit).  
- At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.  
- In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity.  
- If the individual(s) making the affidavit has (have) information that explains why documentary evidence establishing the applicant’s claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.  
- The state must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual guardian or representative, explaining why the evidence does not exist or cannot be obtained.  
- The affidavits must be signed under penalty of perjury. |
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<tr>
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<th>Description/ Explanation</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td>State or Territory Driver License</td>
<td>DR</td>
<td>Driver license issued by a state or territory either with a photograph of the individual or other identifying information of the individual, such as name, age, sex, race, height, weight, or eye color.</td>
</tr>
<tr>
<td>5</td>
<td>School Identification Card</td>
<td>SI</td>
<td>School identification card must have a photograph of the individual.</td>
</tr>
<tr>
<td>5</td>
<td>School Records</td>
<td>ED</td>
<td>When using other school records, such as a report card, day care, or nursery school record, the document must be verified with the issuing school.</td>
</tr>
<tr>
<td>5</td>
<td>Written Affidavit (Form F-10154)</td>
<td>SW</td>
<td>An affidavit of identity is only acceptable for children under 18 years of age. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of birth of the child and cannot be used if an affidavit for citizenship was provided. The parent or guardian does not have to declare their citizenship in this affidavit. Use this code if presented with the Statement of Identity for Children Under 18 Years of Age, F-10154. This affidavit can be used for children under age 18 when they have nothing else. The identity affidavit (F-10154) does not require a notarized signature.</td>
</tr>
<tr>
<td>5</td>
<td>Certificate of Degree of Indian Blood or Other U.S. American Indian or Alaska Native Tribal Document</td>
<td>TR</td>
<td>Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.</td>
</tr>
<tr>
<td>5</td>
<td>Native American Tribal Document</td>
<td>TR</td>
<td>Must have a photograph or other personally identifying information that relates to the person named on the document.</td>
</tr>
<tr>
<td>5</td>
<td>Multiple Identity Documents</td>
<td>OI</td>
<td>An individual may provide three or more corroborating ID documents to verify their identity.</td>
</tr>
<tr>
<td>5</td>
<td>U.S. Military Card or Draft Record, Military Dependent’s Identification Card, or U.S. Coast Guard Merchant Mariner Card</td>
<td>MI</td>
<td>Must show identifying information that relates to the person named on the document.</td>
</tr>
<tr>
<td>5</td>
<td>Identification Card Issued by Federal, State, or Local Government</td>
<td>GI</td>
<td>Must have the same information as is included on driver license.</td>
</tr>
<tr>
<td>Doc Level</td>
<td>Acceptable Documentation</td>
<td>Valid CARES Code</td>
<td>Description/ Explanation</td>
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</tr>
<tr>
<td>5</td>
<td>FoodShare Identification Requirement met</td>
<td>FS</td>
<td>Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FS, it is also met for the new identity verification requirement for Medicaid/BadgerCare Plus. The new &lt;FS&gt; code will be entered by CARES when there is a request for FoodShare and a valid FS verification code for identity is entered in the existing verification code field. When a valid verification code is entered, &lt;FS&gt; will automatically populate in the new Medicaid/BadgerCare Plus verification code field for the Primary Person. &lt;FS&gt; remains a valid Medicaid/BadgerCare Plus verification code for the primary person even if the individual is not currently eligible for FoodShare benefits.</td>
</tr>
<tr>
<td>5</td>
<td>Individual who Previously Received Assistance Through Foster Care, Adoption Assistance or Katie Beckett</td>
<td>OP</td>
<td>Use this code when you are aware that an individual who previously received assistance through Foster Care, Adoption Assistance, or the Katie Beckett Program has provided proof of their citizenship or identification through that program.</td>
</tr>
<tr>
<td>5</td>
<td>Individual is a Continuously Eligible Newborn (CEN)</td>
<td>NB</td>
<td>Use the NB code when a CEN is being added to a case. Citizenship and identity verification is not required for CEN individuals until the next review is done. This code will automatically be removed from the fields at review or intake so that a valid code can be entered at that time.</td>
</tr>
<tr>
<td>5</td>
<td>Medical Record</td>
<td>MR</td>
<td>Clinic, doctor, or hospital record.</td>
</tr>
<tr>
<td>5</td>
<td>Institutional Care Affidavit</td>
<td>IC</td>
<td>A signed F-10175 can also be used when a residential care facility administrator attests to the identity of a disabled individual in the facility.</td>
</tr>
<tr>
<td>5</td>
<td>Motor Vehicle Data Exchange</td>
<td>MV</td>
<td>This code will appear in the identity verification field as a result of a data exchange update with the Division of Motor Vehicles (DMV). This can also be used when verifying an individual’s identity through the DOT Driver License Status Check website. If an applicant requests a backdate for Medicaid/BadgerCare Plus, and the case was updated with an &lt;MV&gt; code on May 7, 2007, CARES will not recognize the &lt;MV&gt; as a valid code for those backdate months. Because the DMV data exchange is valid identity verification, the worker will need to enter &lt;DR&gt; for any backdate months where an &lt;MV&gt; code was updated.</td>
</tr>
</tbody>
</table>
### Level 7 Documentation of Citizenship or Identity

<table>
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<tr>
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</table>
| 7         | Other appropriate documents for Special Populations F-10161 | W7               | Other documents besides those listed in Levels 1-6 can be used to meet the requirement as long as the document meets the general documentation requirement stated here:

“Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen. Any document used to establish identity must show identifying information that relates to the person named on the document.”

A signed [F-10161](#) can only be use for individuals who meet the definition of “Special Populations” and who are unable to obtain any level of acceptable documentation. |
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 a transplant is pending, 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 and 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 approximately 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.

- 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, for example, M.D. 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. If the screener receives no diagnosis information regarding the child, the screener’s notes must document their attempts to obtain diagnosis information.
3.4 Child’s Diagnoses Must Be Current

Accept any medical or professional diagnosis made within the past year. If a diagnosis was made more than a year ago, but is still relevant to the child’s needs and condition, the diagnosis may be entered on the screen even if it was made more than one year in the past. If a screener is performing a rescreen, then they may rely on verification of diagnoses that were obtained and documented for previous screen calculations for the child, unless the child has had a change in condition.

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. Diagnoses of developmental or physical conditions can be accepted without documentation if the parent can recall approximately 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, licensed clinical social worker, or licensed professional counselor for whom diagnosing a mental health disorder is appropriate to their specialization and within the scope of their training and practice.

• 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 persist, and state 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. If a screener is performing a rescreen, then they may rely on verification of diagnoses that were obtained and documented for previous screen calculations for the child, unless the child has had a change in condition.

### 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, for example, 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 IVs. 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 diagnosis 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 make a diagnosis until the child 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 cannot 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 they do 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, P-00920, 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 on which we 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 CCOP 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 Diagnoses for this child are 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 system changes to improve children’s access to primary health care. These data are also required for federal outcome measurements.
4.1 Severe Emotional Disorders Diagnoses Summary

The information listed here is pulled directly from the Diagnoses page. This provides the screener an opportunity to confirm that they have selected the correct 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 (Wis. Stat. ch 938). This does not include court orders for treatment, or a Child in Need of Protective Services (CHIPS) petition (Wis. Stat. ch. 48).

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, or out-of-home placement.

2. If a child has been given a ticket, charged a fine, required to complete restitution, or assigned community service, they are not considered an “adjudicated delinquent.” The child may have committed a crime and is under 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 LOC. Note that the autism spectrum disorders are mental health diagnoses; the screener should check this box for children with those diagnoses. These include Asperger’s syndrome, 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 for children with these diagnoses from a qualified professional (see section 3.5 of instructions). Many people identify these diagnoses as developmental in nature. However, they are also 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 relates 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 anorexia/bulimia, psychosis, and violence, the screener should check the box if one of the following is true:
• The child currently has symptoms as defined.
• The child had the symptoms as defined within the past three months.
• The child had the symptoms as defined at least twice in the past year.

For suicidality, the screener should check the box if the child has had a suicide attempt or significant suicidal ideation or plan in the past 12 months.

Does 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 and/or hallucinations.
☐ Suicidality – Suicide attempt or significant suicidal ideation or plan in the past 12 months.
Violence – Life-threatening acts.

For Anorexia/Bulimia – Life-threatening symptomology, 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:

- Hospitalization of another person (does not include an ER visit).
- Use of weapons against someone (for example, 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)

- 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 (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
o If a child is participating in ongoing treatment, once they have completed the intensive program, then treatment is only listed as mental health services if the specific intervention is overseen by a psychiatrist or psychologist.

o 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:
    o Child has an 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.
    o Child has an active BIP in an 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 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 three 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 four 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:
• To allow screener to describe behavioral symptoms in any child.
• 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 or caregiver but stay within a reasonable distance (for example, 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 (that is, 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 a cotton ball that is soaked with an inhalant, a plastic bag, or balloon, and will cause a mind-altering effect within two to five 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 of 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 who engages in this behavior will attempt to rupture the skin, may bleed, and will most likely scar. A child who bites their nails or cuticles because of a nervous habit would not be considered a child who self-mutilates.

4. **Tearing At or Out Body Parts**—A severe form of self-mutilation that can lead to vision loss from rubbing the eyes, tearing their nose and ears, and any number of other severe injuries. A child who picks at a scab or scratches until a body part bleeds would not be considered a child who 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.

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.

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 or rage when words or outward actions are unacceptable or when the pain is too severe to put into words

AGGRESSIVE or OFFENSIVE BEHAVIOR TOWARD OTHERS

1. **Hitting, Biting, or Kicking**—The aggression involves multiple victims, including at least one non-family member. Aggression is beyond an age-appropriate level. **TWO** of the following are present:
   - Child approaches the incident with the intent to cause harm to others.
   - Incident(s) involves **multiple victims** (more than one).
   - Victim sustains injuries severe enough to require first aid or further medical attention.
   - Others **cannot easily stop** the aggression. The situation requires:
     - Police
     - Police liaison
     - Use of physical protective measures
     - Parents report the use of physical restraint
     - Two or more adults must intervene
   - Child’s repeated acts of aggression have created an atmosphere of fear where the child is seen as a tyrant or abuser.

Hitting, biting, or kicking is not considered an aggressive behavior if a child is reacting in the moment to frustration from a communication/language disorder.

2. **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.

3. **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. 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, or furniture.

4. **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.
5. **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.

6. **Abuse or Torture of Animals**—Abusing animals to find power, joy, or 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 sometime later.

3. **Other (list)**—Not only does the child for whom this answer would be filled in and selected have to demonstrate this very atypical behavior, but that behavior must also 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)
   - Causes extreme distress or disruption to others

**5.3 Frequency of Behavior**

When answering this question, consider the behavior each month over the past six 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 six 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 five 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 two 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 two or three 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 the average frequency of the behavior over the past six months.

*Example E:* The screener meets a child who will bang their head severely but there is no pattern to this behavior. In the past six months the child engaged in this behavior two days the first month, not at all the second or third month, eight days the fourth month, not at all the fifth month and just banged their head twice in the last week. The screener would select the average frequency of the behavior over the past six months and check “1-3 days each month.”

*When answering questions regarding the frequency of behaviors on the functional screen, the screener must remember to consider the impact of current interventions on the child’s behaviors. If the professionals involved agree that the child’s behaviors would resurface if current interventions were discontinued, then the screener is directed to record the frequency of the child’s behaviors prior to receiving the interventions. See section 5.9 of instructions for further guidance.*
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 six months and may be used in the future. If caregivers do not intervene, ignore the behavior, or only use occasional timeouts, check “None” for intervention.

TIMEOUT/SUPERVISION
- Regular timeouts
- 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 in 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 aid (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, specialized locks on windows, or 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” in answer 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 rescreen.

**5.6 Describe Behavior in Detail**

Once a behavior has been selected on the Behavior page it must be described in detail in the textbox immediately following the selected behavior. Some questions to consider are:

- Is there a precursor to this behavior?
- Where does the behavior happen?
- When does the behavior happen?
- What does the behavior look like?
- How severe is the behavior?
- What do others do when the behavior occurs?
- If it is a behavior that occurs in multiple environments, in which environments is it occurring?
- How do you know this information is accurate? What sources of information did you use?

These behavior-specific notes will not be saved with the history screens but will serve to guarantee that the behavior was selected appropriately on the functional screen. Any time one of the three drop-downs associated with a previously selected behavior is changed (frequency,
intervention, or duration), the note section will need to be completed. This is a required textbox on the screen.

## 5.7 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 (for example, 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.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Multiple Locations?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High-Risk Behaviors</strong></td>
<td></td>
</tr>
<tr>
<td>Running Away</td>
<td>No</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>No</td>
</tr>
<tr>
<td>Dangerous Sexual Contact</td>
<td>No</td>
</tr>
<tr>
<td>Use of Inhalants</td>
<td>No</td>
</tr>
<tr>
<td><strong>Self-Injurious Behaviors</strong></td>
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</tr>
</tbody>
</table>
5.8 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.

5.9 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, and intervention of the specific behavior prior to receiving the intervention. In addition, the screener must select that the behavior is expected to last six 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 six 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 printout 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 (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 eligibility) 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,” that is, 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 check marks 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 ADL on a regular basis, as defined by the functional screen questions. 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 their 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, 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, which 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, which 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 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 their 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 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 needs help with his ADLs then; at other times, he is independent with them. Juan gets chemotherapy one week each month. The 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. The screener does not check the 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 ADLs and IADLs, screeners must determine if the child functions within normal limits prior to selecting any specific item(s) under a category (for example, 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 overused to express screeners’ subjective opinions. The CLTS FS is intended to be an objective screen of a child’s need for assistance. Thus, the screener should ask, “Would another screener of another discipline rank the child the same way?"

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." Just because a child is physically capable of completing a task independently does not mean the child does not need assistance. Sometimes it takes a child so long that the parent must do the task so the child gets to school on time. This is not just for convenience and amounts to most of the time (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.

It is not uncommon for a child or parent to underrate the need for assistance. Screeners should use the following process when determining a child’s level of help needed:

- Ask more questions and rely on professional 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.
• Seek additional information from other people, such as the other parent, other family members, teachers, therapists, physicians, and others who interact with the child in a variety of settings.
• Ask, “Given all this information, what would other screeners choose for an answer?

To review an example of how to use this process, please see Section 1.8 A. of the instructions.

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, for example, at home and at school. Please review those earlier sections as needed under 1.8 Screening Limitations.

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 into 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 ADLs 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 ADLs and IADLs, it is 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 many children also attend early childhood, day care environments, or various school programs. Older children 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?

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 ADLs and IADLs 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, do not consider those results to be an accurate reflection of the child’s abilities.
- If the child was considered “un-testable,” do not assume that they would meet a 30% delay or two 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, do not consider those results to be an accurate reflection of the child’s abilities.

Make special note of the number of months and 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:
1. Assessment date (MM/YYYY)
2. Name of the assessment tool
3. 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 and 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 and 85, which is one to two 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, two 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% 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-equivalency (AE) scores. For example, if a 12-year-old child took a norm-reference test and had a valid result with an age-equivalency score of 6;6 (years; months), 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-equivalency 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 AE 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, multiply by 12, and add the additional number of months.

**Examples:**
- If a child’s age is 5 years, 7 months or AE is 5;7:
  - 5.6 years (7÷12=.58=0.6, 5+0.6=5.6)
  - 67 months (5x12+7=67)
- If a child’s age is 2 years, 11 months or AE is 2;11:
  - 2.9 years (11÷12=0.9, 2+0.9=2.9)
  - 35 months (2x12+11=35)

To determine percent delay:
- Take the valid AE score and divide it by the child’s age at the time of testing. This tells you the percent they scored on the assessment.
- Subtract the percent they scored from 1.0 or 100%.

**Example A:** A child who was 8 years old at the time of testing scores a valid AE score of 6. Start by taking 6 divided by 8 and your result is .75 or 75% (6 ÷ 8 = .75), which is the percent the child 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 child who was 9-and-a-half years old at the time of testing scores a valid AE score of 6;2.

In Years: Take 6.16 (their AE score in years) divided by the 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 AE score in months) divided by the 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 AE score of 8;9.

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

In Months: Starting with 105, the AE score in months, divided by the age at the time of testing, in this case 160 months; 105 ÷ 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 and 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 standard deviations below the norm to be considered a substantial functional impairment.

For children a year old or older:

- Normal limits score is considered between 70 and 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 standard deviations below the norm to be considered a substantial functional impairment.

**Full-Scale Intelligence Quotient (IQ)**

The full-scale IQ scores are used as a way to address the overuse and under-use of the diagnosis of intellectual disability. There are limitations of IQ testing. The federal definition of intellectual disability is a full-scale IQ below 70. Federal guidelines do acknowledge an IQ score error range of five points. DHS 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 taken. 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. 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 IADL.

Regardless of the assessment results, once a valid, norm-referenced, standardized assessment or IQ has been entered under Communication or Learning on the IADL page, the rest of the items under Communication or Learning will become null and void. If the testing indicates that a child has a substantial functional impairment, then the duration question will automatically be answered “Yes.” If the results do not support a substantial functional impairment, then the duration question will automatically be answered “No.”
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, and so on). 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 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 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.
### 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 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.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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- **☑ Indicates that the item on the functional screen should be checked.**
- **○ 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.**

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.

- ☑ Uses shower chair, tub bench, mechanical lift, or any other devices if they are used to compensate for the child’s physical impairment.
- ☑ The parents or caregivers prefer another method and have not obtained adaptive equipment.
- ☑ The child is a year or older and unable to maintain a sitting position unsupported.

**Becomes agitated requiring alternative bathing methods.**

- ☑ Becomes unsafe in bathing and needs to be constrained or sponge bathed.
- ○ Takes a shower rather than a bath.
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<thead>
<tr>
<th>Age</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
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- **Indicates that the item on the functional screen should be checked.**
- **Indicates that the item on the functional screen should NOT be checked.**

Is combative during bathing (e.g., flails, takes two caregivers to accomplish task).

- Extreme avoidance behaviors that make bathing unsafe for child or caregiver.
- Caregiver is in tub with child because of child’s unsafe behavior.

**Needs complete physical assistance.**

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. This also includes children ages 9 and older who need an adult to set the water temperature for them.

- Requires someone to bathe them (hands on) whether in a bath or shower. Remember, this does not include hair washing.

**Needs to be lifted in and out of bathtub or shower.**

- Able to get in and out, but parent chooses to lift them.
- Needs hands-on assistance, verbal cues, or supervision but can get in and out without others lifting them.

**Needs help getting in and out of bathtub or shower.**

- Needs hands-on assistance, someone to do the task completely, verbal cues, or close supervision throughout the task.

**BATHING**
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<th></th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-18 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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<tr>
<td><strong>Needs step-by-step cueing to complete the task.</strong></td>
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<td>☑ Needs someone with them throughout the bath or shower telling them each step of the process.</td>
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<td>☑ Needs reminder to bathe (for example, “Don’t forget to take a bath tonight”).</td>
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<td>☑ Needs reminders before the bath takes place (for example, “Remember to wash under your arms”).</td>
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<td>☑ Needs an occasional cue, but not step-by-step instructions.</td>
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<td>☑ Needs prompts throughout the bathing process to stay on task (for example, “Have you washed your body yet?”).</td>
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<td><strong>Lacks an understanding of risk and must be supervised for safety.</strong></td>
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<td>☑ It is understood that if the screener checked “Is combative during bathing,” then this would also be checked.</td>
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<td><strong>Exhibits noncompliant behavior that is extreme to point that child does not perform bathing tasks for five or more consecutive days.</strong></td>
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<td>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.</td>
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<td>☑ Refuses to bathe for at least five consecutive days each week.</td>
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<td>☑ Refuses to bathe for five or more days occasionally but not consistently over the past six months.</td>
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<td>☑ Refuses due to a fine motor limitation.</td>
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<td>☑ Refuses due to a sensory issue.</td>
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<td>☑ Refuses due to a motor coordination issue.</td>
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</table>
6.10 Grooming
Brushing teeth, washing hands and face. Due to variations in hair care by culture, length of hair, and so on, hair care is not considered for the purposes of this screen.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
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<th>12-18 mos</th>
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<th>14-18 yrs</th>
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<td>Indicator</td>
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<td>✔</td>
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<td>❌</td>
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</tbody>
</table>

- ✔ Indicates that the item on the functional screen should be checked.
- ❌ 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).
  - ✔ Exhibits avoidance behavior that is extreme and requires atypical intervention.
  - ✔ Needs one caregiver to hold them while another completes the task.
  - ❌ Runs around the house to avoid grooming tasks.
  - ❌ Doesn’t like grooming tasks and fusses a bit but not more than some peers.

- Unable to wash hands.
  - ✔ Has picture cards or other visual cues and requires assistance from others to use the cues to complete the process.
  - ✔ Unable to turn on the faucet, apply soap, and rinse hands under the water.
  - ❌ Unable to select an appropriate water temperature.
  - ❌ Independently uses picture cards or other visual cues to complete the process.
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs someone with them throughout the grooming process telling them each step of the process.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>24 mos-4 yrs</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>4-6 yrs</td>
<td>☑ Unable to wash face using a wash cloth.</td>
<td>☑ Needs parent or caregiver to wash hands.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>6-9 yrs</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>12-14 yrs</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>18 yrs +</td>
<td>☑ Unable to turn on the faucet, apply soap, and rinse hands under the water.</td>
<td>☑ Needs parent or caregiver to brush teeth.</td>
<td>☑ Needs step-by-step cueing to wash hands.</td>
<td>☑ Needs reminders to groom self.</td>
</tr>
<tr>
<td>Age Group</td>
<td>✓ Indicates that the item on the functional screen should be checked.</td>
<td>✖ Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td></td>
<td><strong>Exhibits noncompliant behavior that is extreme to point that child does not brush their teeth for five or more consecutive days.</strong></td>
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<tr>
<td></td>
<td><em>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.</em></td>
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<tr>
<td></td>
<td>✓ Does not brush teeth for at least five consecutive days each week.</td>
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<td></td>
<td>✖ Does not brush teeth for five or more days occasionally but not consistently over the past six months.</td>
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<td></td>
<td>✖ Refuses due to a fine motor limitation.</td>
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<td></td>
<td>✖ Refuses due to a sensory issue.</td>
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<tr>
<td></td>
<td>✖ Refuses due to a motor coordination issue.</td>
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<td></td>
<td>✖ Does not wash hands or face for several days—not a serious hygiene or health issue.</td>
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</table>
### 6.11 Dressing
The ability to dress as necessary. This does not include the fine motor coordination for buttons and zippers.

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

**Dressing**

- ☑ Indicates that the item on the functional screen should be checked.
- ◇ Indicates that the item on the functional screen should NOT be checked.

Needs physical assistance with getting clothing on. This does not include fasteners such as buttons, zippers, and snaps.

At this age it is expected that typically developing children can dress themselves.

- ☑ A parent or caregiver needs to hold pants while a child steps into them or help pull a shirt over the child’s head.
- ☑ Puts clothing on by self but clothing is inside out, or backwards (not including underwear), or shoes are on the wrong feet.
- ◇ Can dress independently but needs help with fine tuning (for example, tucking shirt in, zipping pants, buttoning shirt).
### 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).

<table>
<thead>
<tr>
<th></th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receives tube feedings or TPN.</td>
<td>✓</td>
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<tr>
<td>Needs help with tube feedings or TPN.</td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Requires more than three hours per day for feeding or eating.</td>
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<td>✓</td>
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<tr>
<td>Requires more than one hour per feeding.</td>
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<td></td>
<td></td>
<td>✓</td>
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</tbody>
</table>

- ✓ Indicates that the item on the functional screen should be checked.
- ○ Indicates that the item on the functional screen should NOT be checked.
- Toddlers who nibble all day long.
- Children who are picky eaters or eat “junk food” all day.
- Food preparation time for special diets.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Needs to be fed.</th>
<th>Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>✓ Cannot feed self enough (orally) to obtain adequate nutrition.</td>
<td>✓ Needs to be monitored for life-threatening choking incidents.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>✓ Is tube fed. Instead, check “Receives tube feedings or TPN,” and, if true, &quot;Needs help with tube feedings or TPN.”</td>
<td>✓ Has Prader-Willi Syndrome and all food access must be controlled.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>✓ Able to feed self but makes a mess or doesn’t use utensils, so the parent prefers to feed child.</td>
<td>✓ Is monitored because of concerns the child will choke, but the child has no history of choking while eating.</td>
</tr>
<tr>
<td>18-24 mos</td>
<td>✓ Able to feed self, but parent prefers to feed the child.</td>
<td>✓ Will stuff mouth with food, often resulting in gagging or vomiting.</td>
</tr>
<tr>
<td>24 mos-4 yrs</td>
<td></td>
<td>✓ Has current eating disorder requiring one-on-one monitoring at meals.</td>
</tr>
<tr>
<td>4-6 yrs</td>
<td></td>
<td>✓ Avoids certain foods, gags, or spits out foods due to oral sensitivities.</td>
</tr>
<tr>
<td>6-9 yrs</td>
<td></td>
<td>✓ Parents or caregivers thicken liquids for the child who can be left to drink without one-on-one monitoring.</td>
</tr>
<tr>
<td>9-12 yrs</td>
<td></td>
<td>✓ Has food cut into bite-size pieces but does not require monitoring during the meal.</td>
</tr>
<tr>
<td>12-14 yrs</td>
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<tr>
<td>14-18 yrs</td>
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<tr>
<td>18 yrs +</td>
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</tbody>
</table>

- ✓ Indicates that the item on the functional screen should be checked.
- ☑ Indicates that the item on the functional screen should NOT be checked.
### 6.13 Toileting

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>☑</strong> Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td><strong>☒</strong> Indicates that the item on the functional screen should NOT be checked.</td>
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Applicable questions for the purposes of this screen have been covered on the Health-Related Services Section.

- **Has no awareness of being wet or soiled.**
  - ☑ Does not know or care that their diaper or underpants are wet or soiled.

- **Does not use toilet/potty chair when placed there by a caregiver.**
  - ☑ Will sit on toilet or potty chair but does not use it to void.

- **Incontinent during the day (of bowel and/or bladder).**
  - 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.
  - ☑ Is incontinent once a day on school days (that’s most days throughout the week).
  - ☑ Has accidents because they did not get to bathroom on time.
  - ☑ Is wet between self-cathing intervals.
  - ☒ Uses pull-ups to have bowel movements but has control of their bowel.
  - ☒ Behavioral problems involving voiding or defecating.
  - ☒ Uses a catheter with some leakage.
<table>
<thead>
<tr>
<th>Age</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs physical help (other than wiping).</td>
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<tr>
<td>☑ Child consistently needs hands-on assistance to use toilet.</td>
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<tr>
<td>☀ Child is not able to wipe self after a bowel movement but is otherwise independent in toileting.</td>
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<tr>
<td>☀ Needs assistance getting on or off toilet.</td>
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<tr>
<td>☀ Uses adaptive equipment with toileting (for example, hand bars)</td>
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<tr>
<td>Needs physical help, step-by-step cues, or a toileting schedule.</td>
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<tr>
<td>☑ &quot;toileting schedule&quot; 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.</td>
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<tr>
<td>☑ Parent or caregiver performs catheterization or assists the child with cathing.</td>
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<tr>
<td>☑ Needs help wiping following a bowel movement.</td>
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<tr>
<td>☑ Needs help changing menstrual pads.</td>
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<tr>
<td>☀ Requests a pull-up or diaper for the purpose of defecating in it.</td>
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<tr>
<td>☀ Can self-cath at regularly scheduled intervals.</td>
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<tr>
<td>☀ Parent or caregiver wakes a child to urinate at the same time every night to prevent bedwetting.</td>
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<tr>
<td>☀ Needs assistance getting on or off toilet.</td>
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<tr>
<td>☀ Uses adaptive equipment with toileting (for example, hand bars)</td>
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<tr>
<td>Incontinent of bowel during the night.</td>
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<tr>
<td>Age Group</td>
<td>Incontinent (of bowel and/or bladder).</td>
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<tr>
<td>0-6 mos</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>6-12 mos</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>12-18 mos</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>18-24 mos</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>24-36 mos</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>36 mos-4 yrs</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>4-6 yrs</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>6-9 yrs</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>9-12 yrs</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>12-14 yrs</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>14-18 yrs</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>18 yrs +</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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</tbody>
</table>

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.

- Is incontinent once a day on school days (that’s most days throughout the week).
- Has accidents because they did not get to bathroom on time.
- Is wet between self-cathing intervals.
- Uses pull-ups to have bowel movements but has control of their bowel.
- Behavioral problems involving voiding or defecating.
- Uses a catheter with some leakage.
### 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.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicates that the item on the functional screen should be checked.</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Indicates that the item on the functional screen should NOT be checked.</strong></td>
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</tr>
<tr>
<td><strong>Not applicable for purposes of this screen.</strong> This option does not appear on the functional screen because young children are expected to require assistance in this category.</td>
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</tbody>
</table>

- **Unable to maintain a sitting position when placed.**
  - ✅ Pillows or props are used, and the child still cannot support their own trunk
  - ⏳ Pillows or props are used, and the child is able to maintain a sitting position.

- **Unable to move self by rolling, crawling, or creeping.**
  - ✅ Cannot move self.
  - ⏳ Can do one but not the others.

- **Unable to pull to stand.**

- **Unable to sit alone.**
  - ✅ Needs pillows or props to support the child in a seated position.
  - ⏳ Needs parent or caregiver to place child in a seated position.

- **Unable to creep or crawl.**
  - ⏳ Able to creep but not crawl.
  - ✅ Able to crawl but not creep.
<table>
<thead>
<tr>
<th>Age</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14+ yrs +</th>
</tr>
</thead>
</table>

- **☑** Indicates that the item on the functional screen should be checked.
- **☒** Indicates that the item on the functional screen should NOT be checked.

### Requires a stander or someone to support the child’s weight in a standing position.

- ☑ Cannot stand even if they have something to hold onto.
- ☑ Does not have the strength in their legs to support their own weight.
- ☒ Can support their own weight, for example, cruising on furniture or using a walker.

### Uses a wheelchair or other mobility device not including a single cane.

- ☑ Uses a mobility device that is generic or specialized equipment to compensate for a physical impairment in mobility.
- ☑ Uses a wheelchair or walker.
- ☑ Uses generic equipment (e.g., a stroller), **only** if it is used to compensate for the child’s physical mobility impairment.
- ☒ Uses ankle-foot orthoses (AFOs), braces, or a single cane.

### Unable to take steps holding on to furniture.

- ☑ Can pull to stand with the aid of furniture but then cannot take a step.
- ☒ Can take a small number of steps.
- ☒ Cannot pull to stand. Instead the screener would check “Requires a stander or someone to support the child’s weight in a standing position.”

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**MOBILITY**
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not walk or needs physical help to walk.</th>
<th>Needs to hold someone’s hand in order to walk.</th>
<th>Requires another person to help hold the child up while they walk.</th>
<th>Can cruise holding onto furniture.</th>
<th>Walks independently with equipment such as a walker.</th>
<th>Fatigues while walking.</th>
<th>Can walk but falls down often.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>18-24 mos</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>24 mos-4 yrs</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>4-6 yrs</td>
<td>☑</td>
<td>☑</td>
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<td>❌</td>
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<td>❌</td>
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<tr>
<td>6-9 yrs</td>
<td>☑</td>
<td>☑</td>
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<td>❌</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>9-12 yrs</td>
<td>☑</td>
<td>☑</td>
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<td>❌</td>
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<tr>
<td>12-14 yrs</td>
<td>☑</td>
<td>☑</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>14 yrs-18 yrs</td>
<td>☑</td>
<td>☑</td>
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<td>❌</td>
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<tr>
<td>18 yrs+</td>
<td>☑</td>
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</tbody>
</table>

☑ Indicates that the item on the functional screen should be checked.

☒ Indicates that the item on the functional screen should NOT be checked.

**MOBILITY**
### 6.15 Transfers
The physical ability to move between surfaces: for example, from bed or 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 and out of a car or other vehicle.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Needs to be transferred</th>
<th>Needs physical help with transfers</th>
<th>Uses a mechanical lift</th>
<th>Uses a mechanical lift with or without assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-12 mos</td>
<td>☐</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>12-18 mos</td>
<td>☐</td>
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<tr>
<td>18-24 mos</td>
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<tr>
<td>24 mos-4 yrs</td>
<td>☐</td>
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<tr>
<td>4-6 yrs</td>
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<td>6-9 yrs</td>
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<td>9-12 yrs</td>
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<td>12-14 yrs</td>
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<td>14-18 yrs</td>
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<tr>
<td>18 yrs +</td>
<td>☐</td>
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</tbody>
</table>

☑ Indicates that the item on the functional screen should be checked.

☒ 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.
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, to complete, “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 a child with Down syndrome, for example, 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, it is expected that a child with a significant hearing impairment would have this item checked: “Does not startle, jump or blink to sudden, loud, unexpected noises.” 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.

Nonverbal/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 nonverbal and uses a Dynamite to express themselves, to complete, “Does not join familiar words into phrases (for example, ‘me drink,’ ‘red truck’),” the screener would inquire if they are combining words on their Dynamite.

Assessment of 30% delay or two standard deviations
A list of tools that are norm referenced for receptive and expressive language is available on the functional screen website at www.dhs.wisconsin.gov/LTCare/FunctionalScreen/cltsfs/assesstools.pdf. The latest editions of the test should always be used when available. Select the correct tool from the drop-down menu on the CLTS FS. Indicate the date (MM/YYYY) that the assessment was completed.
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:
   - Assessment of Basic Language and Learning Skills
   - Brigance Diagnostic Inventory
   - Carolina Curriculum for Infants/Toddlers with Special Needs
   - Child Curriculum Inventory Profile
   - Denver Developmental Screen
   - Developmental Assessment for Individuals with Severe Disabilities
   - Developmental Assessment of Young Children
   - Developmental Observation Checklist System (DOCS)
   - Early Learning Accomplishment Profile (E-LAP)
   - Measurement of Language Utterance (MLU)
   - Non Speech Test for Expressive and Receptive Language
   - Portage Guide to Early Education
   - Receptive Expressive Emergent Language Scale (REEL)
   - Rossetti Infant Toddler Language Scale
   - Transdisciplinary Play-Based Assessment

2. Communication assessments that do not measure expressive or receptive communication:
   - Bracken Basic Concept Scale
   - Communication Abilities Diagnostic Test (CADeT)
   - Gard Gillman and Gorman Pragmatic Language Scale
   - Goldman Fristoe Test of Articulation
   - Greenspan-Lewis Affect Basic Language Curriculum
   - Language Processing Test (LPT)
   - Northwestern Syntax Screening Test
   - Peabody Picture Vocabulary Test (PPVT)
   - Test of Early Reading Ability (TERA)
   - Test of Pragmatic Language (TOPL)
   - Test of Word Finding (TWF)

3. Tools that measure something other than expressive and receptive language but contain subcategories 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.
   - Adaptive Behavior Assessment System
   - Adaptive Behavior Scale
   - Adolescent Test of Problem Solving
   - Autism Rating Scale
   - Battelle Developmental Inventory (BDI)
   - Bayley Scales of Infant Development
   - Behavioral Language Assessment Form
   - Differential Ability Scale (DAS)
- Early Learning Measure (ELM)
- Eau Claire Child Observation Recording Tool (EC-CORT)
- Kaufman Assessment Battery for Children
- Kaufman Brief Intelligence Test
- Kaufman Survey of Early Academic and Language Skills
- Mullen Scales of Early Learning
- Psychoeducational Profile Revised
- Scales of Independent Behavior
- Vineland Adaptive Behavior Scales
- Wechsler Individual Achievement Test (WIAT)
- Wechsler Intelligence Scale for Children (WISC)
- Wechsler Preschool and Primary Scales of Intelligence
- Wisconsin Knowledge and Concepts Examination
- Woodcock-Johnson Test of Achievement
- Woodcock-McGrew-Weder Mini-Battery of Achievement
- WRAT
## 6.16 Communication

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>3-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-17 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
</table>

- **☑ Indicates that the item on the functional screen should be checked.**
- **☒ Indicates that the item on the functional screen should NOT be checked.**

A norm-referenced assessment in receptive language within the last *three 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.)

See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

A norm-referenced assessment in expressive language within the last *three 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.)

See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

A norm-referenced assessment in receptive language within the last *six 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.)

See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

A norm-referenced assessment in expressive language within the last *six 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.)

See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

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.)

See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does Not Startle, Jump, or Blink to Sudden, Loud, Unexpected Sounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>☑ Indicates that the item on the functional screen should be checked. ☐ Indicates that the item on the functional screen should NOT be checked.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>A norm-referenced assessment in expressive 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.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>A norm-referenced assessment in receptive language within the last three years. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 standard deviations (SD) below the mean.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.</td>
</tr>
<tr>
<td>18 yrs +</td>
<td>A norm referenced assessment in expressive language within the last three years. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 standard deviations (SD) below the mean.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.</td>
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<tr>
<td>6-9 yrs</td>
<td>Does not make any vocal sounds (includes crying).</td>
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<tr>
<td>9-12 yrs</td>
<td>☑ Cannot cry out for help (for example, a child with a tracheostomy).</td>
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<tr>
<td>Age Group</td>
<td>0-6 mos</td>
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<tr>
<td><strong>Does not react to changes in tone of voice.</strong></td>
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<tr>
<td><strong>Does not express his/herself through vocal, visual, or gesture exchange.</strong></td>
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<tr>
<td><strong>Does not jabber or babble as if they are trying to say something.</strong></td>
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<tr>
<td><strong>Does not respond to simple requests (e.g., no, stop, come here, give me, look).</strong></td>
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**Indicates that the item on the functional screen should be checked.**
**Indicates that the item on the functional screen should NOT be checked.**
<table>
<thead>
<tr>
<th>Age</th>
<th>Does not point to or look at any familiar objects or people when asked.</th>
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<tbody>
<tr>
<td>0-6 mos</td>
<td>Examples: nuk, bottle, cup, dog, cat, blanky, mama, dada, ball, car.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>☑ Does not respond to requests to look at the puppy (or other items in the child’s day-to-day environment).</td>
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<tr>
<td>12-18 mos</td>
<td>Does not imitate environmental sounds through any means.</td>
</tr>
<tr>
<td>18-24 mos</td>
<td>Examples: animal sounds, up-up-up when walking up the stairs, honk-honk, beep-beep, brrr = car engine.</td>
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<tr>
<td>24-36 mos</td>
<td>☑ Does not copy others when they make silly, familiar sounds.</td>
</tr>
<tr>
<td>3-4 yrs</td>
<td>☑ Doesn’t know the name of animals but can identify them by the sounds they make.</td>
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<tr>
<td>4-6 yrs</td>
<td>Does not use more than 10 meaningful words or word approximations.</td>
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<tr>
<td>6-9 yrs</td>
<td>☑ Only says words when repeating what others say. Does not use spontaneous speech.</td>
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<tr>
<td>9-12 yrs</td>
<td>☑ People familiar with the child understand the word approximations.</td>
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<tr>
<td>12-14 yrs</td>
<td>☑ Is not understood by strangers.</td>
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<tr>
<td>14-17 yrs</td>
<td>☑ Uses word approximations, such as “bah” for “bottle.”</td>
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<tr>
<td>18 yrs +</td>
<td>Does not join familiar words into phrases (e.g., “me drink,” “red truck”, “baby cry”, “no juice”).</td>
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<td></td>
<td>☑ Uses only phrases that have no meaning to the people familiar to the child. For example, “bottle truck,” “baa quack.”</td>
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<td></td>
<td>☑ Uses primarily single words to communicate, although parents or caregivers have heard a few two-word phrases emerging.</td>
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<td></td>
<td>☑ Only combines words that are commonly taught together, almost as one word, such as bye-bye, thank you, all done, or all gone.</td>
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<tr>
<td></td>
<td>Does not point to or look at three familiar objects or people when asked.</td>
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<tr>
<td></td>
<td>Examples: nuk, bottle, cup, dog, cat, blanky, mama, dada, ball, car.</td>
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<tr>
<td>Age Group</td>
<td>0-6 mos</td>
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<tr>
<td>Yes</td>
<td>☑</td>
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<tr>
<td>No</td>
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- Indicates that the item on the functional screen should be checked.
- Indicates that the item on the functional screen should NOT be checked.

<table>
<thead>
<tr>
<th>Description</th>
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<th>18 yrs+</th>
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<tbody>
<tr>
<td>Does not follow two-step instructions that are related and are not routine.</td>
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<td>Follows through with one instruction and cannot retain second instruction.</td>
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<tr>
<td>Child is asked to, “Go to your room and bring back your bunny,” and gets to their room but does not come back with their bunny.</td>
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<td>Does not follow any instructions.</td>
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<tr>
<td>Does not use at least 50 words.</td>
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<td>Uses 50 or more words but can only be understood by people familiar with the child.</td>
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<td>Does not use “mine” to indicate possession.</td>
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<tr>
<td>Does not understand any preposition (e.g., in, on, under) in unfamiliar single-step instructions.</td>
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<td>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.</td>
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<td>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 or look at the one requested.</td>
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<td>Uses at least three prepositions but not the ones listed in the example.</td>
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<tr>
<td>Does not combine three or more words into a meaningful sentence.</td>
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<td>Uses primarily single words to communicate, although parents or caregivers have heard three-word phrases emerging.</td>
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<td>Can only be understood by familiar people.</td>
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COMMUNICATION
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<tr>
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<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
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<tr>
<td>✓ Indicates that the item on the functional screen should be checked.</td>
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<td>☑ Indicates that the item on the functional screen should NOT be checked.</td>
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<td>Does not understand at least three prepositions (e.g., in, on, under) in unfamiliar single-step instructions.</td>
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<tr>
<td>Examples: put the block under the chair, put the toy car on the TV, or put the toy in your shoe.</td>
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<td>For children who are non-ambulatory:</td>
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<td>Using two pictures—one of a ball on a table and the other of a ball under the table—have the child point to or look at the one requested.</td>
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<td>Does not ask for objects by naming them.</td>
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<td>May be through verbal language, communication device, sign language, and so on. Cannot be checked for a child who pulls caregiver to the object.</td>
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<td>Does not combine six or more words into meaningful sentences.</td>
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<td>Is not understood by familiar people that have infrequent contact with the child.</td>
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<td>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.</td>
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<td>Does not follow three-step instructions that are related and are not routine.</td>
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<td>1. Take your dishes to the sink.</td>
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<td>2. Rinse them.</td>
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<td>3. Place them in the dishwasher.</td>
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<td>1. Pick up your toy.</td>
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<td>2. Take it to your room.</td>
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<td>3. Put it in your toy box.</td>
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<td>For children who are nonambulatory:</td>
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<td>1. Tell me your name,</td>
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<td>2. Tell me your address.</td>
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<td>3. Tell me your birth date.</td>
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<td>For children who are nonambulatory and nonverbal:</td>
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<td>1. Point to your eyes.</td>
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<tr>
<td>2. Point to your nose.</td>
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<td>3. Point to your mouth.</td>
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<tr>
<td>Age Group</td>
<td>Communication Skills</td>
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<tr>
<td>0-6 mos</td>
<td>✔️ Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>6-12 mos</td>
<td>✔️ Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>12-18 mos</td>
<td>Do not check if child understands the request but refuses to comply. It doesn’t matter in what order they complete the tasks. Do check if the only instructions a child can follow are part of their daily routine.</td>
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<tr>
<td>18-24 mos</td>
<td>✔️ Can follow three unrelated instructions, such as, “Turn off the TV, put your books away, and make yourself a snack,” but they are not able to follow a series of three related instructions, such as, “Collect the garbage from upstairs, tie the bags tight, and put them on the curb.”</td>
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<tr>
<td>24-36 mos</td>
<td>✔️ 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.”</td>
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<tr>
<td>3-4 yrs</td>
<td>Does not follow two single-step instructions given at the same time that are unrelated and not routine.</td>
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<tr>
<td>4-6 yrs</td>
<td>Examples:</td>
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<tr>
<td>9-12 yrs</td>
<td>1. Put your bike away. 2. Feed the dog.</td>
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<tr>
<td>12-14 yrs</td>
<td>For children who are nonambulatory: 1. Point to your nose. 2. Tell me the day of the week.</td>
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<tr>
<td>14-17 yrs</td>
<td>For children who are nonambulatory and non-verbal: 1. Point to the window. 2. Nod your head “yes.” Do not check if child understands the request but refuses to comply. It doesn’t matter what order they complete the tasks in.</td>
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<td>18 yrs +</td>
<td>Does not use language to share information other than basic needs or wants. Examples include giving directions, describing feelings, providing details.</td>
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<td>Age Group</td>
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<td>Indication</td>
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<tr>
<td>0-6 mos</td>
<td>✓</td>
<td>Indicates that the item on the functional screen should be checked.</td>
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<td>3-4 yrs</td>
<td>✓</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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</table>

- **Is not understood by strangers.**
- **✓** Able to communicate messages to others even though some words may be unclear.
- **☐** 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-to-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.

Assessment of 30% delay or two standard deviations
A list of the tools that are norm referenced for cognitive development is available on the functional screen website at www.dhs.wisconsin.gov/LTCare/FunctionalScreen/cltsfs/assesstools.pdf. The latest editions of the test should always be used when available. Select the correct tool from the drop-down menu on the CLTS FS. Indicate the date (MM/YYYY) that the assessment was completed.

The following are commonly used assessments that DO NOT qualify as norm-referenced tools of cognition:
1. Not norm-referenced, standardized tools:
   • Assessment, Evaluation, and Programming System (AEPS)
   • Brigance Diagnostic Inventory of Early Development
   • Brigance Inventory of Basic Skills
   • California Ordinal Scales of Development
   • Carolina Curriculum (CCITSN or CCPSN)
   • Early Learning Accomplishment Profile
   • Hawaii Early Learning Profile Assessment Checklist (HELP)
   • Southern California Ordinal Scales of Development
   • Transdisciplinary Play-Based Assessment (TBA)

2. Achievement tests that do not test cognitive ability
   • Boehm Test of Basic Concepts
   • Cognitive Abilities Test (CogAT)
   • Developmental Assessment of Young Children (DAVC)
   • Kaufman Test of Educational Achievement (KTEA)
   • Measures of Academic Progress (MAPS)
   • Peabody Individual Achievement Test Revised (PIAT-R)
   • Test of Cognitive Skills (TCS)
   • Wechsler Individual Achievement Test
   • Wide Range Achievement Test (WRAT)
3. Measurement of behavior or adaptive skills (not tests of cognitive ability)
   - Achenbach’s Child Behavior Checklists (CBCL)
   - Adaptive Behavior Assessment System
   - Adaptive Behavior Scales (ABS)
   - Behavioral Style Questionnaire
   - Child Development Inventory
   - Developmental Observation Checklist System (DOCS)
   - Developmental Profile II (DPII)
   - Early Coping Inventory (ECI)
   - Infant/Toddler Sensory Profile
   - Infant Toddler Developmental Assessment (IDA)
   - Psycho-Educational Profile-Revised (PEP-R)
   - Scales of Independent Behavior-Revised (SIB-R)
   - Scales of Independent Behavior—Revised (SIB-R)
   - Vineland Adaptive Behavior Scales (VABS)
   - Wisconsin Behavioral Rating Scale
   - Woodcock-Johnson Scales of Independent Behavior

4. Measurement of something other than cognitive ability
   - Clinical Evaluation of Language Fundamentals (CELF)
   - Columbia Mental Maturity Scale (CMMS)
   - Gates Macginitie
   - Integrated Technology Literacy Skills
   - Preschool Language Scale – 4 (PLS-4)
   - Receptive One-Word and Expressive One-Word Picture Vocabulary Test
   - Receptive-Expressive Emergent Language Test (REEL)
   - San Diego Quick Assessment
   - Scholastic Inventory Reading
   - Test of Auditory Reasoning and Processing Skills (TARPS)
   - 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
   - Kaufman Brief Intelligence Test
   - Wechsler Abbreviated Scale of Intelligence
### 6.17 Learning

<table>
<thead>
<tr>
<th>Age</th>
<th>Item to Check</th>
<th>Note</th>
</tr>
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<tbody>
<tr>
<td>0-6 mos</td>
<td>✔️</td>
<td>A norm-referenced assessment in cognition within the last three months. (A substantial functional impairment is defined by results that indicate a delay of 25% or greater or 1.5 standard deviations below the mean.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.</td>
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<tr>
<td>6-12 mos</td>
<td>✔️</td>
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<tr>
<td>12-18 mos</td>
<td>✔️</td>
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<td>18-24 mos</td>
<td>✔️</td>
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<td>24-36 mos</td>
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<tr>
<td>36 mos-4 yrs</td>
<td>✔️</td>
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<td>4-6 yrs</td>
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<td>6-9 yrs</td>
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<td>9-12 yrs</td>
<td>✔️</td>
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<tr>
<td>12-14 yrs</td>
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<td>14-18 yrs</td>
<td>✔️</td>
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<tr>
<td>18 yrs +</td>
<td>✔️</td>
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</table>

- ✔️ Indicates that the item on the functional screen should be checked.
- ☺ Indicates that the item on the functional screen should NOT be checked.

A norm-referenced assessment in cognition within the last six 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.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

A norm-referenced assessment in cognition 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.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

A norm-referenced assessment in cognition within the last three years. (A substantial functional impairment is defined by results that indicate a delay of 30% or greater or 2 standard deviations below the mean.) See note above regarding specific assessment tools that are accepted for this question. See “6.7 Communication and Learning Assessments” for further instruction.

Has a valid full scale IQ. (A substantial functional impairment is defined by a full scale IQ score of 75 or less.) 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.
<table>
<thead>
<tr>
<th></th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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<tbody>
<tr>
<td><strong>Is not soothed when needs are met.</strong></td>
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<tr>
<td>✓ No matter what is offered (food, diaper change, hugs, and snuggles) the child is not soothed.</td>
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<td>✓ Cries throughout the day and night without any predictable pattern.</td>
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<tr>
<td>✓ Is a “colicky” or “fussy” baby but can be soothed with some effort to meet needs.</td>
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<td>✓ Is fussy for a fairly predictable period of almost every day.</td>
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<td><strong>Does not show an interest in people or objects.</strong></td>
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<td><strong>Does not seek objects that were hidden.</strong></td>
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<td>This is a common milestone of typical development called <strong>object permanence.</strong> Intended to determine if a child understands that an object still exists even if it disappears from sight.</td>
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<td>✓ Once an object disappears from sight, the child does not show any indication that they understand that the object itself still exists.</td>
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<td>✓ 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.</td>
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<td><strong>Cannot intentionally bang, shake, or drop toys.</strong></td>
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<td>✓ Grasps toys but does not “play” with toys.</td>
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<td>✓ Drops toys by accident but not with intention.</td>
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<tr>
<td>✓ Engages in these activities <strong>only</strong> as self-stimulation.</td>
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<td><strong>Cannot imitate gestures or activities (e.g., wave bye-bye, clap hands, make faces).</strong></td>
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<td>✓ Does not imitate these activities following a demonstration.</td>
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<tr>
<td>✓ Engages in these activities <strong>only</strong> as self-stimulation.</td>
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<td>0-6 mos</td>
<td>6-12 mos</td>
<td>12-18 mos</td>
<td>18-24 mos</td>
<td>24-36 mos</td>
<td>36 mos-4 yrs</td>
<td>4-6 yrs</td>
<td>6-9 yrs</td>
<td>9-12 yrs</td>
<td>12-14 yrs</td>
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<tr>
<td>✓ Indicates that the item on the functional screen should be checked.</td>
<td>✓</td>
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<td>☐ Indicates that the item on the functional screen should NOT be checked.</td>
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**Does not know any body parts on self or others.**

✓ Does not respond to “Where’s your nose?” or other similar questions.

☐ When asked about a body part, the child shows you on a doll, in pictures, on themselves, or on you.

☐ Only knows one body part.

**Does not place objects in containers during play.**

☐ Places objects in containers seemingly by accident while playing.

☐ Will not place objects in containers based on the direction of others but will do it on their own at other times.

☐ Does not have the physical ability to place objects in a container due to physical limitations.

**Does not connect a familiar action with an expected outcome (e.g., starting the water means a bath or shower).**

✓ Does not know that they are about to go outside when someone brings them a coat.

**Does not know at least three body parts.**

✓Knows the “Head, Shoulder, Knees and Toes” song but cannot identify body parts at any other time.

☐ Only knows three parts of the face.

**Cannot match any basic shapes.**

*Examples: putting a round lid on a pot, putting a square lid on Tupperware.*

✓ Given a wooden puzzle with three pieces, a square, circle, and a triangle, the child cannot place any piece correctly.

☐ Child with quadriplegia can match shapes by sight.

☐ Given a wooden puzzle with three pieces, a square, circle, and a triangle, the child can place one piece correctly consistently.
<table>
<thead>
<tr>
<th>Item</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
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<th>12-14 yrs</th>
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<tbody>
<tr>
<td>Cannot identify objects in pictures by naming or pointing.</td>
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<td>Cannot match three shapes or three colors.</td>
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<td>Examples for shapes: sorting blocks, using a shape sorter, matching animal crackers, sorting pictures or stickers of shapes.</td>
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<td>Examples for colors: sorting socks, mittens, M&amp;Ms, crayons, vitamins.</td>
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<td>Cannot rote count to 10 without mistakes.</td>
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<td>☑ Counts to 10 but usually misses a couple of numbers along the way.</td>
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<td>☒ Counts to 10 consistently but doesn’t know the value of the numbers.</td>
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<td>Cannot maintain an attention span of at least three minutes for an enjoyable activity (not including self-stimulating behavior).</td>
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<td>Cannot accurately identify at least seven colors.</td>
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<td>Colors include red, green, blue, yellow, orange, purple, violet, brown, white, black, grey, pink, silver, gold, turquoise, navy, teal, fuchsia, maroon.</td>
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<td>Examples of questions: “Show me blue,” or “Which picture is yellow?”</td>
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<td>Cannot accurately identify at least five shapes.</td>
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<td>Shapes include circle, square, triangle, rectangle, oval, heart, diamond, star, moon, crescent, cone, sphere, cube, cylinder, hexagon, trapezoid, parallelogram, pentagon, arrow, pyramid</td>
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<td>Examples of questions: “Show me square,” “Where is the circle?” or “Point to the triangle.”</td>
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<td>Cannot count three objects.</td>
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<td>Example: “Give me three blocks.”</td>
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<td>☑ Can only repeat counting when done by another person or TV show.</td>
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<td>☑ Can count to three or even higher but does not know that numbers represent a certain quantity of things.</td>
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<td>Age Group</td>
<td>Cannot group objects by category.</td>
<td>Does not know common opposites (e.g., tall-short, more-less, hard-soft).</td>
<td>Does not understand sequencing of events.</td>
<td>Cannot name 10 colors.</td>
<td>Does not recognize their first and last name.</td>
<td>Is two or more grade levels behind in two academic subjects.</td>
<td>Cannot tell time on a digital clock or watch.</td>
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<td>6 mos</td>
<td>☑ Indicates that the item on the functional screen should be checked.</td>
<td>☀ Indicates that the item on the functional screen should NOT be checked.</td>
<td>Examples: dogs and cats are animals, cars and trucks are vehicles, bananas and apples are fruit.</td>
<td>Examples: hear a story and put pictures in order (1. running water, 2. washing, 3. drying), (1. mixing cake, 2. baking cake, 3. eating cake), (1. planting a seed, 2. watering, 3. growing plant).</td>
<td>☑ Can recite the alphabet or other memorized rote sequences but cannot sequence pictures from a story.</td>
<td>☑ Parent report only, no documentation.</td>
<td>☑ Recites digits like an eye chart but does not really read the time.</td>
<td>☀ Able to read time but cannot relate time to their daily schedule.</td>
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<td>Age Groups</td>
<td>0-6 mos</td>
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<td>12-18 mos</td>
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<td>(\checkmark) Indicates that the item on the functional screen should be checked.</td>
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<td>(\circ) Indicates that the item on the functional screen should NOT be checked.</td>
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### Cannot identify coins by name.

*By name means penny, nickel, dime, quarter.*

- \(\checkmark\) Able to identify some but not all.
- \(\circ\) Able to identify names of coins but not their value.

### Cannot provide primary phone number.

- \(\circ\) Phone number is not memorized but child can provide it when asked by pulling out a piece of paper where it is written.

### Cannot provide primary address.

*Includes house number, street, and city.*

- \(\circ\) Does not have address memorized but can provide it in written form.

### Cannot make change for a dollar.

*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.*

- \(\checkmark\) Doesn’t understand that four quarters equals one dollar.
- \(\checkmark\) Has no concept that money has value.
- \(\circ\) Cannot figure out how much change they should receive from a dollar for a purchase that cost $.53.
- \(\circ\) Knows that 10 dimes equals one dollar.
<table>
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<th>0-6 mos</th>
<th>6-12 mos</th>
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<tr>
<td>✓ Indicates that the item on the functional screen should be checked.</td>
<td>✗ Indicates that the item on the functional screen should NOT be checked.</td>
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Requires supervision due to inability to problem solve routine issues.

Example: if child missed their ride (bus, parent forgot to pick up after school), would the child know what to do?

✓ 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.

✗ The reason the child needs supervision is due to impulsivity or potential to participate in mischievous acts.

Does not use time to follow a schedule.

✓ Cannot understand the passage of time.

✓ Does not relate time to activities throughout the day.

✓ Can recite the time, but time has no meaning to them.

✗ Does not make good use of their time or procrastinates.

Is three or more grade levels behind in two academic subjects.

✓ Parent report only, no documentation.
6.18 Social Competency

Social competency is composed of self-awareness, social awareness, self-management, relationship management, and responsible decision making. Unlike many ADL/IADLs, social competency is a skill that continues to develop throughout childhood for all children. As children age, the skills required for social competency become much more sophisticated and subtle. 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. It would be uncommon for a child with significant behavior or functional limitations to be at the same social competency level as that of peers of the same age.

If a child is unable to develop the social skill due to a physical, 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 statements is, “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 their temper. As this example demonstrates, the inability to perform a primary social act (have disagreements with other children) as a result of a physical, communication, or learning impairment can be why a child may seem to meet the identified areas for an age cohort under an item in the screen (Does not control his/her temper in disagreements with other children), while failing to meet questions under younger age cohorts or all of the components of social competency. When a child’s inability to perform a primary social act prevents them from performing a subtle social act, the screener should make selections in these areas, even though the child may not have the specific deficit referenced. In these cases, screeners must include detailed notes to explain selections made on the screen.
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).

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<th></th>
<th>0-6 mos</th>
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<tr>
<td>Does not offer a social smile to immediate family.</td>
<td>![ ] (Indicates that the item on the functional screen should be checked.)</td>
<td>![ ] (Indicates that the item on the functional screen should NOT be checked.)</td>
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<td>A social smile occurs in response to a noise, something within baby's sight, or another person's smile.</td>
<td>![ ] (Does not smile.)</td>
<td>![ ] (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.)</td>
<td>![ ] (Smiles in response to a noise, something in their sight, or another person’s smile.)</td>
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<tr>
<td>Does not calm down within a half an hour when soothed by a parent.</td>
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<td>![ ] (Indicates that the item on the functional screen should NOT be checked.)</td>
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<td>Unable to respond to comforting actions from familiar adults.</td>
<td>![ ] (Continues to cry for more than half an hour after all efforts to meet the baby’s needs have been exhausted.)</td>
<td>![ ] (Cries frequently but calms after comforting (fed a bottle, changed a diaper, snuggled).)</td>
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<tr>
<td>Does not enjoy being picked up and held by family members.</td>
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<td>![ ] (Indicates that the item on the functional screen should NOT be checked.)</td>
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<td>Stiffens and arches back when picked up.</td>
<td>![ ] (Reacts adversely to being touched by family members.)</td>
<td>![ ] (Occasionally will resist being picked up or held by family members.)</td>
<td>![ ] (Doesn’t like one particular family member touching them.)</td>
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<td>Age Group</td>
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<td><strong>Does not demonstrate separation anxiety.</strong>&lt;br&gt;Does not become upset or cry when primary caregivers or parents leave.</td>
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<td>☓ Indicates that the item on the functional screen should NOT be checked.</td>
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<td>✔ Is not concerned when their parents leave them in a new environment.</td>
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<td>☓ No longer cries or becomes upset when parents leave because they have become accustomed to the setting (for example, day care).</td>
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<td>☓ Cries or becomes upset when parents leave because they are emotionally attached to them.</td>
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<td><strong>Does not show an interest in what others around them are doing.</strong>&lt;br&gt; Ignores other people in immediate environment.</td>
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<tr>
<td>✔ 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.</td>
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<tr>
<td>✔ Does not react to an adult trying to engage with them (for example, being silly, playing with a toy near them, and offering to play a game).</td>
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<tr>
<td>☓ Is involved in an activity that holds their complete attention (such as TV) and does not notice when others enter the room.</td>
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<tr>
<td>☓ When given the opportunity to watch a toy or watch a person, generally child would rather watch other people.</td>
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<tr>
<td><strong>Does not want to play near or be with immediate family members.</strong>&lt;br&gt;Prefers to be alone rather than near those they trust.</td>
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<tr>
<td>✔ Backs away from others or shows a preference to be alone.</td>
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<tr>
<td>☓ Won’t actively play or interact with others but enjoys being near others.</td>
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</tbody>
</table>

**SOCIAL COMPETENCY**
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Social Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not play simple interactive games (for example, So Big, Peek-a-Boo, Pat-a-Cake).</td>
<td></td>
</tr>
<tr>
<td>Does not respond to other’s attempts to engage in playful exchange.</td>
<td></td>
</tr>
<tr>
<td>To avoid cultural differences, this question is general to capture any type of interactive games played with young children.</td>
<td></td>
</tr>
<tr>
<td>Regardless of encouragement from trusted adults, or other children, will not play simple games.</td>
<td></td>
</tr>
<tr>
<td>Plays some interactive games but doesn’t like other ones.</td>
<td></td>
</tr>
<tr>
<td>Does not enjoy interacting with immediate family members.</td>
<td></td>
</tr>
<tr>
<td>Does not like family time looking at books, listening to songs, or rough-and-tumble play.</td>
<td></td>
</tr>
<tr>
<td>Resists activities with family members and would rather be alone.</td>
<td></td>
</tr>
<tr>
<td>Is apprehensive about interacting with other children or familiar adults outside of their immediate family.</td>
<td></td>
</tr>
<tr>
<td>Does not like to be around other children.</td>
<td></td>
</tr>
<tr>
<td>Prefers to spend time alone even when other children are around.</td>
<td></td>
</tr>
<tr>
<td>Typically chooses a space in a room with other children where they can be away from the other children.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Doesn’t have opportunity to be around other children due to complex or fragile health condition.</td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL COMPETENCY**
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not make sure his/her parents are nearby when exploring new places.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicates that the item on the functional screen should be checked.</td>
</tr>
<tr>
<td></td>
<td>🍁 Indicates that the item on the functional screen should NOT be checked.</td>
</tr>
<tr>
<td>0-6 mos</td>
<td>Approaches new environments without fear or caution.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>Investigates all new surroundings boldly without making sure parents are around.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>Checks in, at least visually, with a parent as they begin a journey into new places.</td>
</tr>
<tr>
<td>18 mos-1 yrs</td>
<td>Doesn’t continuously seek a parent during their exploration.</td>
</tr>
<tr>
<td>18 yrs +</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not enjoy interacting with nonfamily members.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicates that the item on the functional screen should be checked.</td>
</tr>
<tr>
<td></td>
<td>🍁 Indicates that the item on the functional screen should NOT be checked.</td>
</tr>
<tr>
<td>0-6 mos</td>
<td>Would prefer to avoid trusted adults or children outside of immediate family.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>Refuses to interact with familiar people outside of immediate family. This may include neighbors, sitters, and extended family members like grandparents, cousins, or others they do not live with.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>Doesn’t interact with strangers.</td>
</tr>
<tr>
<td>18 mos-1 yrs</td>
<td>Willing to test the waters by interacting with people not in their immediate family.</td>
</tr>
<tr>
<td>18 yrs +</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not show an interest in a variety of toys.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicates that the item on the functional screen should be checked.</td>
</tr>
<tr>
<td></td>
<td>🍁 Indicates that the item on the functional screen should NOT be checked.</td>
</tr>
<tr>
<td>0-6 mos</td>
<td>Does not enjoy playing with a number of toys designed for their developmental level.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>Shows interest in items like fans, lights, and doors in absence of playing with toys designed for their developmental level.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>Has a favorite toy that they prefer to play with but shows some interest in other toys as well.</td>
</tr>
<tr>
<td>18 mos-1 yrs</td>
<td></td>
</tr>
<tr>
<td>18 yrs +</td>
<td></td>
</tr>
</tbody>
</table>

SOCIAL COMPETENCY
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not parallel play with other children.</th>
<th>Does not assume different roles in play.</th>
<th>Does not play in group games with adult supervision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>☑ Indicates that the item on the functional screen should be checked.</td>
<td>☑ Indicates that the item on the functional screen should NOT be checked.</td>
<td>☑ Indicates that the item on the functional screen should be checked.</td>
</tr>
<tr>
<td>6-12 mos</td>
<td>Watches other children play from a distance but does not try to engage in similar activities near other children.</td>
<td>Is not able to pretend to be someone or something other than themselves.</td>
<td>Refuses to engage in group games even with adults directing the play.</td>
</tr>
<tr>
<td>12-18 mos</td>
<td>Engages in cooperative play (for example, building a block tower) with other children. This demonstrates a more advanced social skill.</td>
<td>Will pretend but doesn’t want others to watch. Child can often be overheard playing make-believe by themselves in their room.</td>
<td>Demonstrates initial hesitation and watches for a while before joining in.</td>
</tr>
<tr>
<td>18 mos - 4 yrs</td>
<td>Doesn’t have opportunity to be around other children due to complex or fragile health condition.</td>
<td>Is able to play make-believe games but doesn’t like to. Would prefer to play something else.</td>
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<tr>
<td>4-6 yrs</td>
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<tr>
<td>6-9 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-12 yrs</td>
<td></td>
<td></td>
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<tr>
<td>12+ yrs</td>
<td></td>
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<td></td>
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</tbody>
</table>

**SOCIAL COMPETENCY**
<table>
<thead>
<tr>
<th>Age</th>
<th>Does not take turns in play.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Indicates that the item on the functional screen should be checked.</td>
</tr>
<tr>
<td></td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
</tr>
</tbody>
</table>

- **6 mos**
  - **Indicates** that the item on the functional screen should be checked.
  - **Does not** share toys or wait for their turn in a group game.

- **6 - 12 mos**
  - **Indicates** that the item on the functional screen should not be checked.
  - Is unable to play games like duck-duck-goose, because only one person is “it” and others have to wait their turn.

- **12 - 18 mos**
  - **Indicates** that the item on the functional screen should not be checked.
  - Will not share their own toys but will share toys typically shared in group settings (for example, shovels in the sandbox, swings on the playground).

- **18 mos - 4 yrs**
  - **Indicates** that the item on the functional screen should be checked.
  - Is unable to play games like duck-duck-goose, because only one person is “it” and others have to wait their turn.

- **4 - 6 yrs**
  - **Indicates** that the item on the functional screen should not be checked.
  - Will not share their own toys but will share toys typically shared in group settings (for example, shovels in the sandbox, swings on the playground).

- **6 - 9 yrs**
  - **Indicates** that the item on the functional screen should be checked.
  - Does not insist on trying to do things independently.
  - Willingly allows others to help in all activities throughout the day.

- **9 - 12 yrs**
  - **Indicates** that the item on the functional screen should not be checked.
  - Does not have the “me do” or “I can do it myself” attitude to activities that they have the physical ability to accomplish.

- **12 - 14 yrs**
  - **Indicates** that the item on the functional screen should be checked.
  - Does one activity on their own but is unwilling to try to complete other activities independently.

- **14 - 18 yrs**
  - **Indicates** that the item on the functional screen should not be checked.
  - Has the attitude and willingness to do many activities of daily living throughout the day but doesn’t like putting away their toys or other activities that may be more like a chore.

- **18 yrs +**
  - **Indicates** that the item on the functional screen should be checked.
  - Has the interest in doing things for themselves but does not have the physical or cognitive ability to complete the task.

- **Indicates** that the item on the functional screen should not be checked.
  - Wants to do things by themselves, but gets frustrated to the verge of tantrums when problems arise: paint that drips, paper airplane that will not fold right.

- **Indicates** that the item on the functional screen should be checked.
  - Does not have an awareness of another child’s need for help or feelings.
  - Does not recognize when another child is happy, sad, or hurt.

- **Indicates** that the item on the functional screen should not be checked.
  - Is oblivious to the feelings of others.

- **Indicates** that the item on the functional screen should be checked.
  - Is not aware when another child needs help.

- **Indicates** that the item on the functional screen should not be checked.
  - Knows the other child needs help but doesn’t know what to do to meet that other child’s need.

- **Indicates** that the item on the functional screen should be checked.
  - Can acknowledge the other child is happy, sad, or hurt but doesn’t feel empathy for the child.
<table>
<thead>
<tr>
<th>Age Range</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>6-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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</thead>
</table>

- **☑ Indicates that the item on the functional screen should be checked.**
- **☒ Indicates that the item on the functional screen should NOT be checked.**

**Does not identify one special friend.**

*Will play with anyone but does not have a best friend.*

-☑ Plays with anyone who will play with them but does not seek out a particular friend with whom they are more compatible.

-☑ Does not have any friends.

-☒ Their best friend changes from week to week due to disagreements or any other reason. We are not measuring long-term relationships.

**Does not participate in groups at play.**

*Prefers to play by self rather than be part of a group.*

-☑ When welcomed to join a group activity (for example, game of tag, make-believe games, building with blocks) chooses to play alone instead.

-☒ Is not invited to join a group at play.

-☒ Doesn’t know how to ask permission to join a group or initiate a group activity with others.

-☒ Doesn’t have opportunity to be around groups due to complex or fragile health condition.

**Does not seek information or assistance from parents or teachers.**

*Does not ask for help (verbally or nonverbally) or seek information from a trusted adult.*

-☑ Does not ask teachers when they have a question or need help.

-☒ Is shy and needs encouragement to talk to adults other than parents or teachers but can ask teacher questions in school.

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**SOCIAL COMPETENCY**
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Does not make transitions from one activity to another without disrupting others.</th>
<th>Does not question rules or punishments viewed as unfair.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mos</td>
<td>Indicates that the item on the functional screen should be checked.</td>
<td></td>
</tr>
<tr>
<td>6-12 mos</td>
<td>Indicates that the item on the functional screen should NOT be checked.</td>
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<tr>
<td>12-18 mos</td>
<td></td>
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<td>18 mos</td>
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<tr>
<td>18 mos - 4 yrs</td>
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<tr>
<td>4-6 yrs</td>
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<td>6-9 yrs</td>
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<td>9-12 yrs</td>
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<td>12-14 yrs</td>
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<td>14-18 yrs</td>
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<td>18 yrs +</td>
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</table>

**Does not make transitions from one activity to another without disrupting others.**

*Unable to make transitions without having their discomfort affect others in the group.*

- [✓] Cannot end an activity when it is time to move onto something else without making a scene and bothering others.
- [✓] Is provided extra time in their school day to make transitions when other children can be in a separate space so this child does not disrupt the process for others. For example, leaves classroom five 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.
- [✓] Doesn’t like making a transition but does not have their disappointment affect others in the group.

**Does not question rules or punishments viewed as unfair.**

*Unable to express their sense of unfairness or simply doesn’t care when things are unfair.*

- [✓] Has no understanding of rules.
- [✓] Cannot tell someone that they believe they were treated unfairly.
- [✓] 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.
- [✓] Child gets upset when they don’t win a game or get to go first and think that this is always unfair.
- [✓] 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.
- [✓] Even though their perception of wrongdoing may be incorrect, they are able to express their sense of unfairness.
<table>
<thead>
<tr>
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<th>Indicates that the item on the functional screen should be checked.</th>
<th>Indicates that the item on the functional screen should NOT be checked.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td>Does not control his/her temper in disagreements with other children. Cannot disagree with peers without escalating into a temper tantrum or running away from the situation.</td>
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</tr>
<tr>
<td>6-12 mos</td>
<td>Cannot express 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.</td>
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</tr>
<tr>
<td>12-18 mos</td>
<td>Cannot engage in disagreements with their peers due to significant limitations in cognition or communication.</td>
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</tr>
<tr>
<td>18 mos-4 yrs</td>
<td>Loses temper on occasion when disagreeing with other children.</td>
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</tr>
<tr>
<td>4-6 yrs</td>
<td>Loses temper in conflicts with parents.</td>
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</tr>
<tr>
<td>6 mos-4 yrs</td>
<td>Can express conflicting opinions while managing own emotions in disagreements with peers.</td>
<td></td>
</tr>
<tr>
<td>4-6 yrs</td>
<td>Does not maintain a friendship with at least one person. Does not demonstrate the interpersonal give-and-take necessary to keep a friendship.</td>
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</tr>
<tr>
<td>6-9 yrs</td>
<td>Unable to have long-term friendships because the moment they don’t get their way, the friendship is over.</td>
<td></td>
</tr>
<tr>
<td>9-12 yrs</td>
<td>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.</td>
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</tr>
<tr>
<td>12-14 yrs</td>
<td>Has friends that they have known for a long time.</td>
<td></td>
</tr>
</tbody>
</table>
| 14-18 yrs | Does not express an interest in spending time with similar aged peers. 
Isolates himself/herself from peers. |
<p>| 18 yrs+  | Does not want to participate in activities with other children. |
|         | Only participates in activities because their parents make them and would rather be left alone. |
|         | Has an interest in participating in activities like after-school programs, scouts, 4-H, sports, music groups, or clubs. |</p>
<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
</tr>
</thead>
</table>

- Indicates that the item on the functional screen should be checked.
- Indicates that the item on the functional screen should NOT be checked.

### Does not show concern for the feelings of friends.

*Does not notice another person’s feelings and offer care or comfort.*

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.

- ✔ Does not recognize that a peer’s feelings have been hurt.
- ✔ Can identify that someone else’s feelings have been hurt but doesn’t know what to do to provide comfort.
- ❏ 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.
- ❏ Demonstrates concern for others when their feelings are hurt, but the effort they make doesn’t result in the other person feeling happy again.

### Is not self-confident in social situations.

*Is not comfortable enough to express their own opinion in everyday peer interactions.*

- ✔ Unable to express own view in conversations with friends.
- ✔ Does not have the cognitive or communication skills necessary to engage in this type of conversation.
- ❏ Is comfortable expressing own opinion with peers who have a similar disability but not with the general population.
- ❏ Is able to assert own opinions in their own social circle but not in large or unfamiliar groups.
- ❏ Is socially assertive and takes the initiative in social situations.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Social Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 mos</td>
<td></td>
</tr>
<tr>
<td>6-12 mos</td>
<td></td>
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<tr>
<td>12-18 mos</td>
<td></td>
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<tr>
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<td>12-14 yrs</td>
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<tr>
<td>14-18 yrs</td>
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<tr>
<td>18 yrs +</td>
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</tbody>
</table>

- Indicates that the item on the functional screen should be checked.
- Indicates that the item on the functional screen should NOT be checked.

**Does not assert social autonomy from parents.**

- Does not make decisions about interests, activities, or ideas independent from parents.
- Unable to make decisions affecting own daily life.
- Completely dependent on parents to make all decisions for them.
- Able to make and follow through with own decisions, live by own set of rules about right and wrong, and be less emotionally dependent on their parents.
- Consults with parents to help make decisions but ultimately makes final decision for themselves.

**Repeatedly does not avoid situations that are likely to result in trouble.**

- Gets involved in situations that have caused trouble in the past or does not avoid peer pressure in going along with a bad idea.
- Has received correction or redirection to avoid dangerous or risky situations but continues to participate again and again.
- Demonstrates excessive familiarity with strangers.
- Unable to resist going along with a peer group even though they know the activity is dangerous or risky and should be avoided.
- Able to avoid peer pressure by giving a reason why it is a bad idea to go along, making an excuse as to why they can’t participate, simply saying no, suggesting an alternative activity, or just leaving the situation all together.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-6 mos</th>
<th>6-12 mos</th>
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<tbody>
<tr>
<td>✅ Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td>❄ Indicates that the item on the functional screen should NOT be checked.</td>
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**Does not show respect for other people.**

*Does not get along with a variety of people, use prosocial manners, and show gratitude towards others.*

- ✅ Unable to interact positively with others except for those in their own specific cultural group.
- ❄ Able to demonstrate basic acts of kindness towards others. This includes but is not limited to saying, “Please,” and “Thank you.”
- ❄ Able to interact positively with people who have different values and opinions than their own.
- ✅ Able to interact positively with children and adults with special needs or from different ethnic groups.

**Does not demonstrate the capacity for intimacy with another.**

*Has not established close relationships that are open, honest, caring, and trusting.*

- ✅ Unable to establish same-sex friendships that involve being open, honest, caring, and trusting.
- ❄ Has close same-sex friendships but does not have a romantic relationship with anyone.

**Does not avoid situations that may get him/her into trouble.**

*Makes unhealthy and unsafe decisions concerning drinking alcohol, using drugs, safe driving, safer sex, use of the internet, and other comparable situations.*

- ✅ Repeatedly makes poor choices in situations that may cause harm to self or others.
- ❄ Smokes cigarettes, although it is considered unhealthy and may get them into trouble.
- ❄ Has a legal guardian due to a severe cognitive impairment.
- ❄ Has experimented with unsafe situations but does not persist in them.
- ✅ Has made some mistakes along the way but in general makes healthy and safe decisions.

**SOCIAL COMPETENCY**
### 6.19 Meal Preparation

<table>
<thead>
<tr>
<th>Age Group</th>
<th>6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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</table>

- ☑ Indicates that the item on the functional screen should be checked.
- ❌ Indicates that the item on the functional screen should NOT be checked.

Needs help making simple meals for self.

### 6.20 Money Management

<table>
<thead>
<tr>
<th>Age Group</th>
<th>6 mos</th>
<th>6-12 mos</th>
<th>12-18 mos</th>
<th>18-24 mos</th>
<th>24-36 mos</th>
<th>36 mos-4 yrs</th>
<th>4-6 yrs</th>
<th>6-9 yrs</th>
<th>9-12 yrs</th>
<th>12-14 yrs</th>
<th>14-18 yrs</th>
<th>18 yrs +</th>
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</table>

- ☑ Indicates that the item on the functional screen should be checked.
- ❌ Indicates that the item on the functional screen should NOT be checked.

Needs help with managing money.
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 (their 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, and so on) 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 is 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. 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 six 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, the screener answers “Yes” to this question.

Is the child currently home-schooled?

If the child is home-schooled for any reason, select “Yes” for this question. This does not include homebound instruction offered by the school district. Home-school does not include any virtual education programs, such as Wisconsin Virtual Academy.

Is the child currently attending high school?

For the purposes of the screen, ninth through 12th grade are considered 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.

**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 system improvements for children ages 14-18 and their parents. The screener will check services that have been identified for the child by their support team.

### 7.2 Employment

Please be sure to discuss the questions in this section with all children and families during every screening. Engaging children and families in discussions about employment early and often is an important part of overall employment preparedness. Children are five times more likely to work in the community as an adult if the adults in their lives, especially their parents, expect that they will work. Starting these conversations when children are young and providing them with information and resources helps with transition planning, goal setting, and determining employment outcomes.

**Current employment status**
- **Current employment** means the person has a job and is working at that job.
- **Not employed** means the person does not have a job and is not working.
- **Employed part time** means the person works less than 30 hours a week.
- **Employed full time** means the person works 30 hours a week or more.

**Employment Interest**
- **Interested in a job** means employment in the community is a goal for the child and family.

Please use this question as an opportunity to provide information and resources to children and families about how they can prepare for future employment. Key areas to help children and families explore as part of the preparation and planning process include the following:
- Seeking an inclusive school experience, starting in preschool.
- Working with their school to develop an academic and career plan (ACP) that reflects children’s goals for their future and includes a plan for achieving those goals. All children develop ACPs starting in sixth grade.
- For children who have an individualized education program (IEP), encouraging their school to include key elements of the ACP in their IEPs.
- Using the planning the families have already done to help develop meaningful goals for the postsecondary transition plan (PTP), which is developed at age 14.
- Applying for services through the Division of Vocational Rehabilitation (DVR).
• Supporting children and families by providing planning resources and attending IEP meetings.

Additional information on how SSCs can help children and families prepare for employment in the community is available through the Think Possible! training on DHS’s website at https://www.dhs.wisconsin.gov/clts/waiver/transition/youcanwork.htm.

If employed, where? (check all that apply)
• **Attends prevocational day/work activity program** is selected if the person currently attends a program designed to teach them concepts needed to perform a job in the community effectively.
• **Attends a sheltered workshop** is selected if the person is working in a segregated facility that exclusively or primarily employs persons with disabilities.
• **Has paid job in the community** is selected if the person is working for pay in the community. Babysitting, mowing lawns, and working at stores, other businesses, or restaurants, are examples of jobs in the community.
• **Works at home** is selected if the person is doing work for pay out of their home. Receiving an allowance for doing tasks around the house is not the same as working at home. An example would be a microenterprise like making jewelry.

Need for assistance to work (optional for unemployed persons)
This section is optional; however, completing it for every child helps determine what services could be considered to help meet that child and family’s employment goals.
• **Independent (with assistive devices if uses them)** means the person could be independent on a job even if they were using assistive devices or technology. For example, a person may need a tablet to assist them to remember their work tasks or an alarm to return from breaks on time.
• **Needs help weekly or less (e.g., if problems arise)** means the person would most likely need minimal help if they were employed. For example, a person’s schedule of activities changes biweekly and they need support when the schedule changes each time.
• **Needs help every day but does not need the continuous presence of another person** means the person could work and would need help, but not one-to-one support. For example, a person needs help setting up their task and their task changes several times a day. This person may need someone to help set up the task, but then can do the task until the next task needs to be set up. The person can do the job independently but needs support to set up the task each time.
• **Needs the continuous presence of another person** means the person would need one-to-one support on an ongoing basis in order to be employed. For example, the person has a court order that they may not be left alone. This person needs one-to-one support on an ongoing basis in order to be employed.
MODULE #8: Health-Related Services

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

- The HRS Table assigns “weights” to each checkbox 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 an 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 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) | ✓ Indicates that the item on the functional screen should be checked. 
✗ Indicates that the item on the functional screen should NOT be checked. |
|--------------------------------------------------------|---------------------------------------------------------------------|
| Rehabilitation program for brain injury or coma – minimum 15 hours/week | ✓ Child has comprehensive home rehabilitation program to address physical, social, and psychological needs to follow recent discharge from a rehabilitation hospital. 
✗ Child has finished inpatient brain injury rehabilitation and is receiving therapies at home or school. 
✗ Child had a brain injury years ago and receives ongoing therapies at home and school. |
| Unable to turn self in bed or reposition self in wheelchair | ✓ Child has quadriplegia and cannot turn self over in bed. (Would expect child to need help with ADLs as well.) 
✓ Child needs someone to reposition them in a wheelchair and in bed to prevent skin breakdown. 
✗ Child can reposition self somewhat in a wheelchair and can turn self in bed. |
| Recurrent Cancer | ✓ “Recurrent cancer” is written in child’s records. 
✓ Parent can clearly state cancer is “recurrent,” or that cancer had gone away and has come back. 
✓ Child was in remission but now cancer is growing again regardless of how much time has passed. 
✓ Child completed chemotherapy last year, but the cancer has come back. 
✓ Child has had radiation therapy, but the cancer has spread to other parts of the body (“metastasized”). 
✓ A new kind of cancer has developed, regardless of how much time has passed since the last cancer was treated. 
✗ Child is still in first series of treatment. 
✗ Screener is not sure whether cancer is “recurrent” or still in first round of treatment. |
| Medical or Skilled Nursing Needs (Check all that Apply) |  ✓ Indicates that the item on the functional screen should be checked.  
☐ Indicates that the item on the functional screen should NOT be checked. |
| --- | --- |
| **Stage IV Cancer** | 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.  
 ✓ Parents clearly state that M.D. told them the child has “Stage Four” cancer.  
 ✓ “Stage IV” is written in medical records.  
 ✓ A health care provider tells the screener that the child has Stage IV cancer.  
 ☐ Parent says child’s prognosis is poor, but has not heard of “Stage Four,” and the screener does not see it in records. |
| **Tracheostomy** | ✓ Child has a current tracheostomy ("breathing hole" through front of throat).  
 ☐ Child had a tracheostomy in the past that is now almost healed closed. |
| **Ventilator (positive pressure)** | ✓ Child continually uses a mechanical volume ventilator, one that forces air into the lungs.  
 ✓ Child uses a mechanical volume ventilator only while sleeping.  
 ☐ 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)** | ✓ Child receives PT (physical therapy), OT (occupational therapy), or SLP (speech language pathology) from a licensed therapist or an appropriately supervised therapy aide.  
 ✓ Child receives PT, OT, or SLP during the school year but not over the summer, because it is not provided by the school at that time.  
 ✓ PT, OT, or SLP has been recommended at a specific frequency but child has not received it yet.  
 ☐ In-home autism program.  
 ☐ Behavioral therapies.  
 ☐ PT, OT, or SLP has been recommended by a physician but no evaluation of required frequency has been established.  
 ☐ Exercises done by someone other than a therapist or therapy aide.  
 ☐ Child sees a therapist less than once a month. |
<table>
<thead>
<tr>
<th>Medical or Skilled Nursing Needs (Check all that Apply)</th>
<th>✓ Indicates that the item on the functional screen should be checked. ○ Indicates that the item on the functional screen should NOT be checked.</th>
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</table>
| “Less than 6 sessions/week” OR “6 or more sessions/week” | Add all three therapy disciplines to count the number of sessions per week.  
A joint therapy session (for example, 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 followthrough: Exercises, sensory stim, stander, serial splinting/casting, braces, orthotics | 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.  
“Exercises”  
✓ Records indicate the exercises are “PT, OT, SLP therapy follow through.”  
✓ Exercises are part of an individualized treatment plan developed from a therapist’s full assessment, and therapist(s) taught caregivers what to do.  
✓ Parents continue to do therapy exercises with their child, as instructed by therapists, although they and child no longer require therapy oversight at this time.  
○ The exercises are general things like taking a walk or riding a bike.  
“Sensory stimulation”  
✓ A therapist has taught the family or school staff to do sensory stim for a child with tactile sensitivity.  
“Stander” (A special positioning device to place a child in an upright position for weight bearing)  
✓ Child is put into a stander for 30 minutes a day at school.  
○ Child has a stander but doesn’t use it anymore.  
“Serial splinting or serial casting”  
✓ Child’s parents are doing “serial splinting,” applying specially adjusted splints or bivalved casts to progressively stretch the child’s muscles to prevent contractures and facilitate treatment.  
○ Child has worn the same splints (for example, AFOs, KAFOs) for months to prevent contractures. This is not “serial splinting.”  
○ Child is in a total body cast. |
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<tr>
<th>Medical or Skilled Nursing Needs (Check all that Apply)</th>
<th>☑ Indicates that the item on the functional screen should be checked. ☐ Indicates that the item on the functional screen should NOT be checked.</th>
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</table>
| **“Braces, orthotics”**  
☑ Child is unable and parents or caregivers must apply braces or orthotics and monitor for skin and nerve involvement. | |
| **Wound, site care or special skin care** | **“Wound care” (Wound care must be required on a daily basis)**  
☑ Child has special gel dressing (such as Una boot, algiderm, duoderm) that is changed every seven days.  
☑ Parents are changing gauze dressings two or three times a day.  
☑ Parents change dressings twice a day and nurse cleans wound once a week.  
☐ Parents are applying “Band-Aids.”  
**“Site or Special skin care” (Site care must be required on a daily basis)**  
☑ Child requires more than routine site care of an ostomy, catheter, or central venous line (IV).  
☑ Child’s site is severely infected and requires daily dressing change to save the site.  
☑ Child has a rare and severe skin disease that creates open skin, requiring medicine and wrapping.  
☐ 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.

<table>
<thead>
<tr>
<th>Medical or Skilled Nursing Need</th>
<th><strong>Indicates that the item on the functional screen should be checked.</strong></th>
<th><strong>Indicates that the item on the functional screen should NOT be checked.</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>BOWEL or OSTOMY</strong> &lt;br&gt; - Related SKILLED Tasks (digital stim, changing wafer, irrigation) &lt;br&gt; Does not include site care.</td>
<td>☑ Parents report that child receives one or more of the treatments listed in this row.</td>
<td>☒ Child receives suppositories, laxatives, or other medications.</td>
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<td>☑ Parents do “skilled” tasks, including 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.</td>
<td>☒ Child is on a “toileting schedule” but has none of tasks listed in the row.</td>
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<td></td>
<td>☑ Child receives suppositories, laxatives, or other medications.</td>
<td>☒ Someone empties the ostomy bag a few times a day. (This is not a skilled task.)</td>
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<td>☑ Child has urinary ostomy from the bladder. (See Urinary Catheter row.)</td>
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<td><strong>DIALYSIS</strong> &lt;br&gt; (hemodialysis or peritoneal, in home or at clinic)</td>
<td><strong>Sometimes dialysis is only needed a few times; be sure to confirm the duration of over six months.</strong> 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, and so on.</td>
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<td>☑ Child goes to a dialysis clinic every other day. (Check “4-7 days/week” frequency.)</td>
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<td>☑ 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.)</td>
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<td>☑ 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.</td>
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<tr>
<td><strong>IVs - peripheral or central lines - fluids, medications, transfusions.</strong> &lt;br&gt; Does not include site care.</td>
<td>☑ Child goes to outpatient hospital or clinic to receive IV treatments.</td>
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<td>☑ Parent flushes child’s central line once a day.</td>
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<td>☑ Child has a port that is accessed twice a week for chemotherapy.</td>
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<td><em>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.</em></td>
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<tr>
<td>Medical or Skilled Nursing Need</td>
<td>☑ Indicates that the item on the functional screen should be checked.</td>
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<tr>
<td><strong>OXYGEN and/or deep SUCTIONING – With Oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.</strong> Includes use of pulse oximeter and apnea monitor</td>
<td>☑ “Deep” suctioning (down the back of the throat into the windpipe) is being done.</td>
<td>☑ 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.)</td>
</tr>
<tr>
<td><strong>RESPIRATORY TREATMENTS:</strong> Chest PT, C-PAP, Bi-PAP, IPPB treatments (does NOT include inhalers or nebulizers)</td>
<td>Use this row to record frequency for respiratory treatments such as “C-PAP” or “Bi-PAP” and chest physiotherapy and postural drainage.</td>
<td>☑ Child receives chest PT and respiratory therapy from a respiratory therapist.</td>
</tr>
<tr>
<td>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.</td>
<td>☑ Parents and school aides do chest PT and postural drainage twice every day.</td>
<td>☑ Child uses C-PAP or Bi-PAP during sleep times.</td>
</tr>
<tr>
<td>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.</td>
<td>☑ Child receives IPPB treatments one to four 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.)</td>
<td>Definition: IPPB treatments and nebulizers involve pouring a precise amount of liquid medicine into an aerosolizing machine.</td>
</tr>
<tr>
<td>Medical or Skilled Nursing Need</td>
<td>☑ Indicates that the item on the functional screen should be checked. ☐ Indicates that the item on the functional screen should NOT be checked.</td>
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| TPN (total parenteral nutrition) | **Definition:** This is when the child gets all their nutrition through an IV (intravenous) line. (“Parenteral” means outside the gut.)  
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.  
☑ Child cannot receive nutrition through intestinal system, and receives continual TPN. Check “2 or more times a day.”  
☐ 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. This is IV fluid with just a little sugar, not complete nutrition; it is not TPN. |
| TUBE FEEDINGS | **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.  
G-tube (gastrostomy): A feeding tube goes through the abdomen into the stomach.  
J-tube (jejunostomy): A feeding tube goes through the abdomen into the intestine just below the stomach.  
"Mickey": A special button apparatus to hold a G-tube in place.  
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.  
☑ Young child is on a continuous tube feeding. The skilled tasks (checking for proper placement, starting a new bag of feeding, running the pump, and so on) are most often done many times a day. Check the “2 or more times a day” column.  
☑ Child is starting to eat, but receives an eight-hour tube feeding two or three times a week. Check “4 to 7 times/week” column.  
☑ Child can eat by mouth but receives needed hydration through her G-tube. Check frequency of tube feedings for liquids.  
☑ 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. |
<table>
<thead>
<tr>
<th>Medical or Skilled Nursing Need</th>
<th>☑ Indicates that the item on the functional screen should be checked. ☑ Indicates that the item on the functional screen should NOT be checked.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Flushing the tubing after medication administration is not counted as a skilled task.</td>
</tr>
<tr>
<td>URINARY CATHETER-RELATED SKILLED TASKS (straight caths, irrigations, instilling meds). Does not include site care.</td>
<td>Definition: “Straight caths” or “Intermittent urinary catheterizations” are an “in &amp; out” cathing, done usually every four to eight hours. 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 once 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). ☑ Child has a vesicostomy, and the parent needs to dilate it. Check the frequency for which it is dilated. ☑ Child has a continually indwelling catheter almost all of the time. Someone else empties the bag three times a day. The only skilled task is to change the catheter every 60 days. Check “1 to 3 times/month.” ☑ Child has a urinary catheter overnight only. If overnight, putting it in and taking it out count as two separate tasks. Check “2 or more times/day.” ☑ 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 four to seven times a week frequency is most accurate. ☑ 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.” ☑ 12-year-old boy with spina bifida and some learning delays &quot;sort of knows&quot; 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. ☑ Child has vesicostomy and it is draining without dilation. ☑ Routine “cath care” usually just soap and water as normal part of bathing.</td>
</tr>
</tbody>
</table>
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 health care 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 the child’s self-injections due to school policy, but the child is completely *independent* with the task and with monitoring for problems.

☹ The child knows how to check their own blood sugars but usually will not unless an adult reminds them and watches to make sure they do it.

If the child is not independent in managing a condition, place one check mark 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 a nurse’s aide, school aide, or other direct care worker 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 (such as an indwelling urinary catheter), the check mark 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 a 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. The screener places two check marks: 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 six or 12 months. If that averages to almost once a 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 or 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 a 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 six 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 or 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 six 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 in face-to-face meetings with the child 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 one-and-a-half hours, but the child was only present for the last 30 minutes, the screener would put one hour, 30 minutes under face-to-face contact.

Collateral Contacts
This is the amount of time the screener spent in face-to-face meetings and on the phone talking with collateral contacts (such as extended family members, teachers, therapists, health care providers). This also 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 (such as the narrative assessment for the waiver).
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

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:

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

The page will then display the following chart:

<table>
<thead>
<tr>
<th>Eligibility Program</th>
<th>Eligibility Results</th>
<th>Pending Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Community Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Recovery Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Options Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Waivers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie Beckett Medicaid Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Wrap Around</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 **Children's Waiver**, 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 Waiver 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 or county using the Children’s Waiver.

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.

The CLTS FS Functional Screen Information Access (FSIA) pending time frame is 31 days. This allows screeners additional time for reviewing a child’s not functionally eligible (NFE) results, consulting with their agency’s CLTS FS lead, and contacting the DHS CLTS Functional Eligibility Team via the CLTS FS email box to resolve any functional screen issues. When the disenrollment feature of the Eligibility and Enrollment Streamlining (EES) tool is fully functioning, the NFE results will automatically transfer to EES after 31 days and initiate
disenrollment for the CLTS waiver participant. Screeners should continue to check the box to send results to interChange immediately when the calculated result remains eligible.

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 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 email the CLTS FS mailbox for assistance.

If the result is that the child is not functionally eligible, the screener should always request an internal review by their agency or entity. Each agency or entity is responsible for screen and screener quality assurance at a local level. When specific questions arise and eligibility results cannot be verified, consult with state staff by emailing the CLTS FS mailbox.

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
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 Children’s Community Options Program and the results indicate that the child is no longer eligible for the Katie Beckett Program, the Children’s Community Options 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.

This applies when ALL of the following conditions are met:
1. You are a certified screener doing a CLTS FS for a child.
2. You have obtained a Functional Screen Informed Consent from the child’s parent or guardian.
3. You have followed existing procedure to have the screen transferred to you, if necessary.
4. You have determined that a previous screen(s) exists for the child.
5. You have completed the screen and calculated results with which you are in agreement. Per the CLTS FS Instructions, if you disagree with your results, you are responsible for using your agency’s internal CLTS FS review process and, if necessary, contacting CLTS FS email box at dhscltsfs@wisconsin.gov.
6. Your calculated results show that the child’s eligibility has changed to Not Eligible or Not Functionally Eligible for a program(s) other than the one for which you were completing the screen. Note: the child may or may not be a participant in the other program(s).

When the situation meets all of the above conditions, follow the procedure outlined below:
**Step 1:** If the screen results change the child’s functional eligibility for the Katie Beckett Program - Medicaid from Functionally Eligible to Not Functionally Eligible:
1. Send an email to dhskatiebeckett@wisconsin.gov.
   a. In the “Subject” heading state: **Change in FS Results.**
   b. In the “Message” of the email indicate the first and last name of the child, spelled correctly, and describe the change in their functional eligibility results.
   c. Be sure your email includes your full name, title, and phone number.
2. Administrative staff at KBP Central Office will forward your email to the assigned Katie Beckett nurse consultant. The nurse consultant will call you to discuss the screen results.

**Step 2:** If the screen results change the child’s eligibility for any other program (other than Katie Beckett) to Not Eligible or Not Functionally Eligible, then you must also contact all screeners for whom your screen changed eligibility results.

The screeners you contact must reply to you with the needed information within 10 business days. If the previous screener does not reply to your original request for their telephone and fax numbers within 10 business days, then continue with your customary process for finalizing and communicating to the family the eligibility results for your program.

**Step 3:** If the child is currently active on both the Katie Beckett Program – Medicaid and a CLTS Waiver, the screener for the CLTS Waiver takes the lead in the discussion regarding the change in the CLTS-FS results. Katie Beckett Program staff are not involved at this point, because they have had no recent contact with the child for review of eligibility. Refer to **Termination of CLTS Waiver Participation** policy for further information as needed.

**Step 4:** You and the previous certified screener(s) will have a dialogue about the child’s needs and functional eligibility upon the exchange. Remember that there are many reasons why eligibility results may have changed, including a change in the child’s condition, a change in the child’s age, or that the family represented the child’s needs differently. You will discuss the need for any further information with the other screener(s) and agree on a method to collect this. If appropriate, you will make edits to the screen using the new or expanded information gathered during this process and recalculate eligibility.

**Step 5:** If you and the previous screener agree that the results of the most current finalized screen are accurate and reflect your experience with the child and family, then each screener will proceed with the actions appropriate to the program with which they work.

**Note:** The final agreed-upon screen may have changed functional eligibility back to functionally eligible.

If the result of this process is that you and the previous screener are unable to reach an agreement about the screen results, you must refer this situation to the CLTS FS team for a final decision. Send an email to dhscltfs@wisconsin.gov.

### 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 website 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 report formats to choose from. The three reports are:

- **FS report w/eligibility**: This report is a complete report of everything the screener entered in the CLTS FS. 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

Instructions on how to register for the online Children’s Long-Term Support Functional Screen (CLTS FS) course, presented via the DHS Learning Center.

2. Select the “Registration” link.
3. Click on the Registration Account Form link.
   • Print out the form and fill in your information. On the last page, indicate the course you wish to take. Fax or mail the completed form to UW-Oshkosh as indicated on the form. Note: Signatures are mandatory for account registration.
   • Registration account requests are processed within 48 hours. UW-Oshkosh Partner Training Services (PTS) registration staff will notify you by email of your logon ID. Your logon ID becomes your unique personal identification for future functional screen courses hosted on the Learning Center. Retain it for future use.

Accessing the course:
After you receive your logon ID, go to the DHS Functional Screener Learning Center at https://wss.ccdet.uwosh.edu/stc/dhsfunctscreen.
1. Click on the My Curriculum link on the left navigation bar.
2. Select the Children’s Long-Term Support Functional Screen Certification Course.
3. Click on the first Module Code FUNCT_100 to begin the course.

11.2 Obtaining, Deleting, or Changing Access for Certified Screeners

Obtaining Access to the CLTS Functional Screen
To gain access to the CLTS Functional Screen as a certified screener, follow these steps:
1. Go to https://fsia.wisconsin.gov/
2. If you do not already have a WAMS ID, you will need to select the “WAMS” link and create one.
3. Select the “FSIA Request Access” link.
4. Complete the Functional Screen Web Access Request Form.
5. Note, item #10 Profiles = “Children's LTS Functional Screen.”
6. Send the signed Functional Screen Web Access Request Form and the certificate of achievement from the School of Nursing to the state security officer.

Changing Access Information
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.
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.

Restricting Access to the CLTS Functional Screen
When a screener leaves your agency and no longer needs 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, they should have their profile reactivated by the new employer.

11.3 CLTS FS Listserv
Once certified, screeners are strongly encouraged to sign up for the CTLS FS Listserv (https://www.dhs.wisconsin.gov/aboutdhs/alerts.htm). The listserv is the principle way in which DHS will notify you about changes being made to the CLTS FS, 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.

To join or 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.

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, including the following:
- Current clinical instructions
- Diagnosis cue sheet
- Paper form of the CLTS FS
- Age-specific questions for ADL and IADLs
- Links to available webcast

11.5 CLTS FS Coordinator
The CLTS FS email box (DHSCLTSFS@wisconsin.gov) can be contacted regarding specific clinical questions on the CLTS FS. Contact the CLTS FS email box 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 name of the person who
answers the email appear in any individual child’s functional screen. Their recommendations are to the certified screener, not to the screen itself, as they have 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, and finding two files for the same child in the CLTS FS database.

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. Sharing of confidential information without signed consent between county agencies and between county agencies and state staff is outlined in Wis. Stat. §§ 51.30(4)(b) and 51.42, Wis. Admin. Code § 92.04(5), and federal Medicaid laws on confidentiality.

1. **When requesting a screen be transferred:**
   a. Contact the transferring agency and request that they transfer the screen to your agency. Provide the transferring agency with the exact name of the child, the child’s date of birth, and 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.
   b. All requests for transfers from the Katie Beckett Program can be emailed to the KBP Central Office at dhskatiebeckett@wisconsin.gov. In the “Subject” heading state: CLTS FS Transfer.

2. **When transferring a screen:**
   a. Transfer the screen to the requesting agency. Be sure to confirm that you have selected:
      - The correct individual applicant.
      - The correct screen type (such as the adult screen, children’s screen, mental health screen).
      - The correct receiving agency from the drop-down list.
   b. 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 our website at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm. If you need help transferring a screen, contact the SOS Help Desk at:

\[\text{SOS Help Desk}\\text{608-266-9198}\\text{dhssoshelp@wisconsin.gov}\]

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.
   - **INITIAL SCREEN:** Complete an **INITIAL SCREEN** if the child is applying for a different program in the new county.
   - **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. Anytime 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 (such as a narrative assessment for the Waiver). However, this is **not** the primary
The 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.

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 as well as the actual titles of a child’s diagnosis.

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

**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
- 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
- 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
- 09/07/10: Child attempted suicide two months ago. They were released from the hospital. The discharge summary verifies this information. BB

**BEHAVIOR**: Note a detailed description of any check marks for specific behaviors, especially those that 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. Both her parents and the police reports support this. BB
- 09/07/10: Child engages in head banging behavior on a daily basis. She wears a helmet to protect her head both at home and at school. She will strike her head on walls and floors. This accommodation is in her IEP and she was wearing her helmet at the home visit. BB
FIVE ATTRIBUTES OF CLTS FUNCTIONAL SCREEN QUALITY NOTES

Notes contain the evidence, substantiation, or verification to support what is selected (or not selected) on the CLTS FS. There is a reason certified screeners select certain items on the CLTS FS. Notes should provide the facts, details, and specifics that led to those decisions.

Purpose of Quality Notes:
If a screen is reviewed after a period of time (six months, a year, and so on), anyone (such as the screener, the child’s parents, an administrative law judge, the CLTS FS Coordinator, or an agency supervisor) should be able to stand behind the functional screen results with the evidence contained in the note sections on the screen. It must be clear that functional eligibility was determined based on all evidence available at the time of completion by a professional certified screener.

Five Attributes of Quality Notes:

1. PROPER FORMAT
   Dates and initials appear with notes, in desired format:
   a. Newest notes at the top of the note section; and
   b. Date (MM/DD/YY) - Notes - Initials.
   
   Notes appear on every page of the CLTS FS. Proper formatting is important, because uniformity of the most up-to-date note at the top of the note section means anyone reviewing the screen knows where to look for the most relevant information. The format serves the purpose of locking (bookends) in a screener’s notes so that no one else can accidentally add to the notes a screener has written.

2. PROFESSIONAL APPEARANCE
   Notes must reflect a professional, legal, court-ready document. This includes correct spelling and grammar. The CLTS FS represents the screener's best work. Acronyms and abbreviations should not be used. Additionally, a screen with notes that are grammatically correct and correctly spelled will be easier for a subsequent screener or someone reviewing the screen to understand. Writing notes in a Word document where spellcheck can be used is recommended. These notes can then be copied into the CLTS FS.

3. PREVIOUS NOTES ARE ACCURATE OR DELETED
   Previous inaccurate, irrelevant, unprofessional, or no longer applicable notes are deleted from the CLTS FS. Every note on a functional screen must support the child’s current functional abilities. Notes are always saved with screens in the “History” of the CLTS FS. If previous notes remain entirely accurate and pertinent to the current screen, screeners should indicate that this is the case in a newly dated entry.

4. INCORPORATE MULTIPLE SOURCES
   Notes indicate that findings were corroborated from multiple sources of information, and specific sources are identified. Sources must represent the child’s functional abilities in multiple locations throughout their day. Multiple sources are important throughout the screen but are essential on all selected categories on the Mental Health, Behavior, and IADL pages. Sources include the following:
   - Child: observations during the home visit
• Parent: information shared during the home visit and in written form (such as on the application)
• Others: verbal reports from others in the child’s life
• Reports: written documentation of the child’s functional abilities

5. CONTAIN DETAILED EVIDENCE

Notes provide details of the child’s functional ability that led to what was or was not selected on the CLTS FS. Notes present evidence to answer the question, “How would someone know the information selected on the CLTS FS is correct?” Notes:
• Include objective descriptions of skills demonstrated at the home visit.
• Provide evidence gathered from reports.
• Provide facts, including the what, who, why, where, and when, with specific content.

When another person (such as another screener, a hearing officer, or a parent) 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 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

The reports available on the CLTS FS were designed for use by screeners and agencies. To access the reports from any page within the functional screen, select REPORTS from the upper right corner of the page:
Select Children’s Long Term Supports Reports:

There are currently four reports available:

1. **Screen Summary at Agency Level**
   This report helps agencies monitor screens that are incomplete when screeners are completing screens, and the types of screens being completed, among other factors.

   View Screen Summary information by specifying any combination of criteria:
   - County
   - Agency
   - Screener
   - Status (incomplete or complete)
   - Screen Archive Status (active or archived)

   Information can be collected within a specific date range. The report generated can be sorted as specified and created as a PDF document or Excel spreadsheet.
Once all criteria are selected, click SUBMIT.

The report will list:
- Child's Name
- Child’s Date of Birth
- Child’s SSN
- Screener’s Name
- Screen Completed Date
- County of Residence
- County of Responsibility
- Screen Type (Initial or ReScreen)
- Status (Complete or Incomplete)

2. **Screen Time Report**
   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.

   View Screen Time information by specifying any combination of criteria:
   - County
- Screener
- Agency
- Screen Archive Status (active or archived)

Information can be collected within a specific date range. The report generated can be sorted as specified and created as a PDF document or Excel spreadsheet.

Once all criteria are selected, click SUBMIT.

This report will generate a list that includes all of the following information:
- Screener’s Name
- Child’s Name
- Child’s Date of Birth
- Child’s SSN
- Screen Complete Date
- Screen Type (Initial or Annual)
- Screen Time
- Referral Date
- Screen Begin Date
- Days from Referral Date to Screen Begin Date
- 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.
3. **Screener Summary at Agency Level**

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.

View Screener Summary information by specifying any combination of criteria:

- County
- Agency
- Screener Status (Active or Inactive)
- Screener Profile (Child Screener, Child Screener - View Only)

Information can be collected within a specific date range. The report generated can be sorted as specified and created as a PDF document or Excel spreadsheet.
Once all criteria are selected, click SUBMIT.

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)
- Status (Active, Inactive)

4. **SSN Status Report**
   This report is available so that screeners can view applicants who do not have a verified SSN.

   View SSN Status information by specifying any combination of criteria:
   - County
   - Screener
   - Agency
   - SSN Status

   Information can be collected within a specific date range. The report generated can be sorted as specified and created as a PDF document or Excel spreadsheet.
Once all criteria are selected, click SUBMIT.

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

- Child’s Name
- Child’s Date of Birth
- Child’s Gender
- Screener’s Name
- Child’s SSN
- SSN Status

Long Term Care Functional Screen
SSN Status Summary Report

<table>
<thead>
<tr>
<th>Agency:</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Screener Name</th>
<th>SSN</th>
<th>SSN Status</th>
</tr>
</thead>
</table>

Total Applicants:
11.11 Not Functionally Eligible LOC Results

Once functional eligibility is calculated, an icon appears in the upper-right corner of the Eligibility Results page for every child (see image below). Clicking on the “Print NFE Results” icon will open a new PDF document that will outline Not Functionally Eligible (NFE) Results. Note that this option does not work on previous eligibility calculations or history screens. Previously calculated screens will display the Child’s Results as “null.”

The new NFE Results document will outline the criteria for each of the four institutional levels of care. Following the criteria, the specific Child’s Results will be outlined.

Image of the DD Level of Care NFE Results

<table>
<thead>
<tr>
<th>Eligibility Program</th>
<th>Eligibility Results</th>
<th>Pending Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Community Services</td>
<td>Not functionally determined</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>to need services</td>
<td></td>
</tr>
<tr>
<td>Community Recovery Services</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Options Program</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Support Program</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>Home and Community-Based Services-Waivers</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>Katie Backoff Medicaid Eligibility</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>MH Wrap Around</td>
<td>Not functionally eligible</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* This does not include FINANCIAL eligibility *

* These results are for functional eligibility only. Each program/service has additional requirements for enrollment.*
Possible NFE Results for the Developmental Disability (DD) LOC:

- This child does not have a diagnosis of a cognitive disability or a similar diagnosis as required to meet Criterion 1 of the DD Level of Care.
- This child does not demonstrate substantial functional limitations as required to meet Criterion 2 of the DD Level of Care.
- This child has a diagnosis of a cognitive disability or a similar diagnosis but does not demonstrate a substantial impairment in learning as required to meet Criterion 1 of the DD Level of Care.

Possible NFE Results for the Severe Emotional Disturbance (SED) LOC:

- This child does not have a diagnosis of a mental health condition as required to meet Criterion 1 of the SED Level of Care Requirements.
- This child’s mental health diagnosis has not existed for the required duration of time as required to meet Criterion 2 of the SED Level of Care Requirements.
- This child’s mental health diagnosis is not expected to persist for the required duration of time as required to meet Criterion 2 of the SED Level of Care Requirements.
- This child is not currently receiving or in need of involvement with the mental health service system as required to meet Criterion 3 of the SED Level of Care Requirements.
- This child does not exhibit severe symptomology or dangerous behaviors at the intensity or frequency or required interventions to meet Criterion 4; Standards I-VI of the SED Level of Care Requirements.
• This child does exhibit the rare or extreme circumstances or substantial social competency impairment required to meet Criterion 4; Standard VII of the SED Level of Care Requirements.

Image of the NH Level of Care NFE Results

Possible NFE Results for the Nursing Home (NH) LOC:

• This child does not have a diagnosis of a medical or physical disability as required to meet Criterion 1 of the NH Level of Care Requirements.

• This child does not require the skilled nursing interventions or does not have substantial functional limitations required to meet Criterion 2 of the NH Level of Care Requirements.

Image of the HOS Level of Care NFE Results

Possible NFE Results for the Hospital (HOS) LOC: This child does not meet the need for frequent and complex medical care that requires the use of equipment to prevent a life-threatening situation for the required duration.

With the information provided in the NFE Results document, screeners can gather information from the CLTS FS, the institutional levels of care, and all additional documentation they have about the child to formulate a clear and concise explanation of why a child did not meet any one or all four levels of care. This PDF document cannot be shared with families, as it is only a tool for certified screeners to use to guide their final eligibility decision. In addition, this information cannot be used to artificially change a child’s functional eligibility results without documented evidence specifically related to the child’s abilities, needs, and limitations.