

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

## *Individual Information*

Screen Information		
Screening Agency:	Referral Date (mm/dd/yyyy):  / /	
Screen Type (Check only one box): <input type="checkbox"/> 01 Initial Screen <input type="checkbox"/> 02 Annual Screen <input type="checkbox"/> 03 Screen due to change in condition or situation (or by request)	Screener's Name:	Screen Begin Date (mm/dd/yyyy):  / /

Referral Source: (Check only one option.)			
<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> Hospital, Clinic	<input type="checkbox"/> School
<input type="checkbox"/> Other Relative	<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Out-of-Home Setting	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Guardian (Non-Relative)	<input type="checkbox"/> Children with Special Health Care Needs	<input type="checkbox"/> Physician / Clinic	<input type="checkbox"/> Special Needs Adoption
<input type="checkbox"/> Self	<input type="checkbox"/> Family Support Program	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> State Center
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Therapist - Physical, Occupational or Speech Language Pathologist
<input type="checkbox"/> Birth-to-3 Program		<input type="checkbox"/> Public Health	
<input type="checkbox"/> Other - Please specify:			

Child's Basic Information		
<input type="checkbox"/> Primary Contact		
First Name:	Middle Name:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (xxx-xx-xxxx):  - -	Birth Date (mm/dd/yyyy):  / /
County / Tribe of Residence:		County of Responsibility:
Additional County / Tribe of Residence:		Additional County of Responsibility:

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?
<input type="checkbox"/> Yes
<input type="checkbox"/> No

## U.S. Citizenship

- Child has documentation to establish U.S. Citizenship.

Verified by:

- U.S. Passport
  - Certificate of Naturalization: N-550/N-570
  - Certificate of Citizenship: N-560/N-561
  - SSI-MA Recipient
  - Medicare Recipient
  - SSDI Recipient
  - Birth Certificate
  - Certification of Report of Birth: DS-1350
  - Consular Report of Birth Abroad: FS-240
  - Certification of Birth Abroad: FS-545
  - Final Adoption Decree
  - Medicaid Birth Claim
  - Acquired citizenship through parents
  - Hospital Record
- Child does not have U.S. Citizenship but does have the following Alien Registration Number per the verified Permanent Resident Card.
- Alien Registration Number: \_\_\_\_\_ (xxx-xxx-xxx)
- Child claims to have U.S. Citizenship or an Alien Registration Number but required documentation was not provided
- Child is only seeking eligibility for the Family Support Program, Community Options Program, Comprehensive Community Services, and/or Mental Health Wrap Around Program.

## Identity

Identity was verified by:

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

**Ethnicity [Optional]**

Is participant Hispanic or Latino?

- Yes
- No

**Race [Optional] (Check all boxes that apply.)**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

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

- |  |   |
|--|---|
| <input type="checkbox"/> American Sign Language  | <input type="checkbox"/> Hmong                      |
| <input type="checkbox"/> Spanish                 | <input type="checkbox"/> Russian                    |
| <input type="checkbox"/> Vietnamese              | <input type="checkbox"/> A Native American Language |
| <input type="checkbox"/> Other - Please specify: |   |

## Contact Information

Additional Contact 1		
		<input type="checkbox"/> Primary Contact**
<b>Contact Type (check only one option):</b> <input type="checkbox"/> Parent <input type="checkbox"/> Non-legally Responsible Relative <input type="checkbox"/> Guardian of Person <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other – Please specify:		<b>If Power of Attorney, check all applicable types:</b> <input type="checkbox"/> Education <input type="checkbox"/> Financial <input type="checkbox"/> Health Care
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Best time to contact and/or comments:		

Additional Contact 2		
		<input type="checkbox"/> Primary Contact**
<b>Contact Type (check only one option):</b> <input type="checkbox"/> Parent <input type="checkbox"/> Non-legally Responsible Relative <input type="checkbox"/> Guardian of Person <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other – Please specify:		<b>If Power of Attorney, check all applicable types:</b> <input type="checkbox"/> Education <input type="checkbox"/> Financial <input type="checkbox"/> Health Care
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Best time to contact and/or comments:		

**Additional Contact 3** Primary Contact\*\***Contact Type (check only one option):**

- Parent
- Non-legally Responsible Relative
- Guardian of Person
- Power of Attorney
- Representative Payee
- Other – Please specify:

**If Power of Attorney, check all applicable types:**

- Education
- Financial
- Health Care

First Name:

Middle Initial:

Last Name:

Address:

City:

State:

Zip:

Home Phone (xxx) xxx-xxxx:

Work Phone (xxx) xxx-xxxx:

Cell Phone (xxx) xxx-xxxx:

Best time to contact and/or comments:

**Additional Contact 4** Primary Contact\*\***Contact Type (check only one option):**

- Parent
- Non-legally Responsible Relative
- Guardian of Person
- Power of Attorney
- Representative Payee
- Other – Please specify:

**If Power of Attorney, check all applicable types:**

- Education
- Financial
- Health Care

First Name:

Middle Initial:

Last Name:

Address:

City:

State:

Zip:

Home Phone (xxx) xxx-xxxx:

Work Phone (xxx) xxx-xxxx:

Cell Phone (xxx) xxx-xxxx:

Best time to contact and/or comments:

**\*\*Primary Contact Verification**

- I verify that all Primary Contacts have legal right to the person's records.

## Child's Medical Insurance

Insurance Information (check all that apply, include policy number, and clearly write numbers)			
<input type="checkbox"/> Medicare	Policy Number:		
	<input type="checkbox"/> Part A	<input type="checkbox"/> Part B	<input type="checkbox"/> Medicare Managed Care
<input type="checkbox"/> Medicaid	Policy Number:		
<input type="checkbox"/> Railroad Retirement	Policy Number:		
<input type="checkbox"/> Private Insurance # 1 (includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
<input type="checkbox"/> Private Insurance # 2 (includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
<input type="checkbox"/> Other Insurance - Please specify:			
<input type="checkbox"/> No medical insurance at this time			

Primary Care Provider
<input type="checkbox"/> Does the child have a provider that meets most of his/her medical needs (primary care physician)?

If applicant has a primary care provider, please indicate type of provider:
<input type="checkbox"/> Adult Physician (Internist, Gynecologist, Adult Specialist) <input type="checkbox"/> Pediatric Specialist
<input type="checkbox"/> Family Practice Physician <input type="checkbox"/> Pediatrician
<input type="checkbox"/> General Practice Physician <input type="checkbox"/> Physician's Assistant
<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Other – Please specify:

## Living Situation

### Current Residence of the Child: (Check only one option.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> With Parent(s)   | <input type="checkbox"/> Foster Care or Other Paid Caregiver's Home (e.g., 1-2 bed family home) | <input type="checkbox"/> Mental Health Institute/State Psychiatric Institution or Other IMD              |
| <input type="checkbox"/> With Other Unpaid Family Member(s)                                 | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider    | <input type="checkbox"/> No permanent residence (e.g., is in homeless shelter, etc.)                     |
| <input type="checkbox"/> With Legal Guardian  | <input type="checkbox"/> Hospice Care Facility  | <input type="checkbox"/> Nursing Home (includes rehabilitation facility if licensed as a nursing home)   |
| <input type="checkbox"/> Adult Family Home (1-2 bed)  | <input type="checkbox"/> ICF-MR/FDD   | <input type="checkbox"/> Treatment Foster Home   |
| <input type="checkbox"/> Alone (includes person living alone who receives in-home services) | <input type="checkbox"/> DD Center/State Institution for Developmental Disabilities             | <input type="checkbox"/> With Live-in Paid Caregiver(s) (includes service in exchange for room & board)  |
| <input type="checkbox"/> CBRF (1-4 bed)   | <input type="checkbox"/> Licensed Adult Family Home (3 bed)                                     | <input type="checkbox"/> With Non-relatives/Roommates (includes dorm, convent or other communal setting) |
| <input type="checkbox"/> CBRF (5-8 bed)   | <input type="checkbox"/> Licensed Adult Family Home (4 bed)                                     | <input type="checkbox"/> With Spouse/Partner   |
| <input type="checkbox"/> CBRF (more than 8 beds)  |   |  |
| <input type="checkbox"/> Child Caring Institution   |   |  |
| <input type="checkbox"/> Children's Group Foster Home                                       |   |  |
| <input type="checkbox"/> Other (includes juvenile detention or jail) - Please specify:      |   |  |

### If the child is not currently living at home, is the child expected to return home within 6 months of screening date?

- N/A  
 Yes  
 No

### If applicant is age 18 or older, record where the applicant prefers to live: (Check only one option.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> With Parent(s)  | <input type="checkbox"/> CBRF  | <input type="checkbox"/> Mental Health Institute/State Psychiatric Institution or Other IMD            |
| <input type="checkbox"/> With Other Unpaid Family Member(s)  | <input type="checkbox"/> ICF- MR/FDD   | <input type="checkbox"/> Nursing Home (includes rehabilitation facility if licensed as a nursing home) |
| <input type="checkbox"/> With Legal Guardian   | <input type="checkbox"/> DD Center/State Institution for Developmental Disabilities          | <input type="checkbox"/> 1-2 Bed Adult Family Home (certified) or Other Paid Caregiver's Home          |
| <input type="checkbox"/> Alone (includes person living alone who receives in-home services)              | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider | <input type="checkbox"/> Residential Care Apartment Complex  |
| <input type="checkbox"/> With Spouse/Partner   | <input type="checkbox"/> Hospice Care Facility   |  |
| <input type="checkbox"/> With Non-relatives/Roommates (includes dorm, convent or other communal setting) | <input type="checkbox"/> Licensed Adult Family Home (3-4 bed AFH)                            |  |
| <input type="checkbox"/> Unable to determine person's preference for living arrangement                  |  |  |
| <input type="checkbox"/> Other - Please specify:   |  |  |

**Guardian/Family's Preference of living arrangements for this individual: (Check only one option.)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> With Parent(s)  | <input type="checkbox"/> CBRF  | <input type="checkbox"/> Mental Health Institute/State Psychiatric Institution or Other IMD            |
| <input type="checkbox"/> With Other Unpaid Family Member(s)  | <input type="checkbox"/> ICF- MR/FDD   | <input type="checkbox"/> Nursing Home (includes rehabilitation facility if licensed as a nursing home) |
| <input type="checkbox"/> With Legal Guardian   | <input type="checkbox"/> DD Center/State Institution for Developmental Disabilities          | <input type="checkbox"/> 1-2 Bed Adult Family Home (certified) or Other Paid Caregiver's Home          |
| <input type="checkbox"/> Alone (includes person living alone who receives in-home services)              | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider | <input type="checkbox"/> Residential Care Apartment Complex  |
| <input type="checkbox"/> With Spouse/Partner   | <input type="checkbox"/> Hospice Care Facility   |  |
| <input type="checkbox"/> With Non-relatives/Roommates (includes dorm, convent or other communal setting) | <input type="checkbox"/> Licensed Adult Family Home (3-4 bed AFH)                            |  |
| <input type="checkbox"/> Unable to determine person's preference for living arrangement                  |  |  |
| <input type="checkbox"/> Other - Please specify:   |  |  |

**For people 18 years and older who are not living with a parent or other family member, does the person have control over their living situation? (Check only one option.)**

- |   |   |
|---|---|
| <input type="checkbox"/> Own the home   | <input type="checkbox"/> Have control of the setting through a signed agreement with agency or provider.  |
| <input type="checkbox"/> Hold the lease   | <input type="checkbox"/> Have control of the setting through a condition of the provider's certification. |
| <input type="checkbox"/> Hold a co-Signed lease and have control over the physical environment  |   |
| <input type="checkbox"/> Work with an agency that holds the lease, but has control of the setting, and the right to hire and fire providers |   |

## Diagnoses

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

- Yes  
 No  
 Don't Know

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

Child's Diagnoses: (Check all diagnoses that apply.) Indicate

Diagnosis	Is this a PRESENTING diagnosis	Diagnosis	Is this a PRESENTING diagnosis
<input type="checkbox"/> Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Infection – Current or Recurrent Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anemia, (e.g., Sickle Cell, Fanconi's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Limb Missing, Severe Limb Abnormality, Arthrogyriposis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anorexia Nervosa, Bulimia, or Other Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Liver Disease (Hepatic Failure, Cirrhosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Antisocial Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mental Health Diagnosis – Other Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Metabolic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mood Disorder or Dysthymic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asperger's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Multiple Sclerosis or ALS	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Attention-Deficit Disorder, Attention-Deficit Hyperactivity Disorder, or Disruptive Behavior Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muskuloskeletal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Autism or Autism Spectrum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Nutritional Imbalance (e.g, Malnutrition, Vitamin Deficiencies)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blind or Severely Visually Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Obsessive – Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brain Disorder (Other than seizures) or Brain Damage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Oppositional Defiant Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

Diagnosis	Is this a PRESENTING diagnosis	Diagnosis	Is this a PRESENTING diagnosis
<input type="checkbox"/> Brain Injury – Traumatic (per statutory definition of TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis Other than Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis – Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Vascular Accident (CVA) (Pre- or Postnatal)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pica	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cognitive Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Post-Traumatic Stress or Acute Stress Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Congenital Abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Contracture / Connective Tissue Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prematurity / Low Birth Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reactive Attachment Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deaf or Severely Hearing Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Renal Failure or Other Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dehydration / Fluid or Electrolyte Imbalance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Respiratory Condition (other than Asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depersonalization Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rett's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schizophrenia or Other Psychotic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sensory Disorder (other than Blind or Deaf)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sexual and Gender Identity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Digestive System Disorder (of mouth, esophagus, stomach, intestines, gall bladder, pancreas)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Somatoform Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Endocrine Disorder (not Diabetes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spinal Muscular Atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Stereotypic Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

Diagnosis	Is this a PRESENTING diagnosis	Diagnosis	Is this a PRESENTING diagnosis
<input type="checkbox"/> Fetal Alcohol Syndrome / Effect	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance Abuse Diagnosis – Other Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Genetic / Chromosomal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance-Related Disorder, inc. Alcohol Abuse- (not to include Caffeine or Nicotine Addictions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Genitourinary System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tourette's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hemophilia / Other Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichotillomania	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hypochondriasis or Body Dysmorphic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tuberous Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Immune Deficiency</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wound, Burn, Bedsore, Pressure Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Impulse-Control Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> <b>OTHER - Please specify:</b> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## **Mental Health/Substance Abuse**

**Is child currently an adjudicated delinquent?**

- Yes
- No

**If the child has a clinical diagnosis of an emotional disability, has the diagnosis or symptoms related to that diagnosis, persisted for at least 6 months?**

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

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

- Yes
- No

**Does the child have any of the following symptoms? (Check all that apply.)**

- Psychosis — Serious mental illness with delusions, hallucinations, and/or lost contact with reality
- Suicidality — Suicide attempt in past 3 months or significant suicidal ideation or plan in past month
- Violence — Life threatening acts
- Anorexia/Bulimia - Life threatening symptomology
- No symptoms apply

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

- Mental Health Services
- Child Protective Services
- Clinical Case Management and Service Coordination Across Systems
- Criminal Justice system
- In-school Supports for Emotional and/or Behavioral Problems
- Substance Abuse Services
- No services required

**If child currently receives or needs any of the above services, are supports, or would supports be more than 3 hours / week combined?**

- Yes
- No

**Does this child exhibit disruptive behaviors in structured settings on a daily basis that require redirection from an adult at a frequency of every 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

**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

**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

# Behaviors

## \*\* Current Intervention Reference Table

Time-out/Supervision	Medical/Professional Treatment	Emergency
<ul style="list-style-type: none"> <li>Regular time-outs</li> <li>Restricted community access</li> <li>Constant supervision ("in-line of sight")</li> </ul>	<ul style="list-style-type: none"> <li>Professional medical treatment</li> <li>Regular professional therapeutic treatment</li> <li>Regular use of protective gear</li> <li>Environmental restraints</li> <li>Constant supervision ("within arm's reach")</li> </ul>	<ul style="list-style-type: none"> <li>Urgent or emergency medical treatment</li> <li>Police involvement</li> </ul>

### Child's Behavior: (Check all that apply.)

BEHAVIOR	FREQUENCY (over the past 6 months)	CURRENT INTERVENTION	EXPECTED to LAST 6 MONTHS or MORE?
<i>**Refer to 'Current Intervention Reference Table' above for more information on 'Current Intervention' dropdown options.</i>			
<b>High-Risk Behaviors</b>			
Running Away	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dangerous Sexual Contact	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Use of Inhalants	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Self-Injurious Behaviors</b>			
Head-Banging	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>BEHAVIOR</b>	<b>FREQUENCY (over the past 6 months)</b>	<b>CURRENT INTERVENTION</b>	<b>EXPECTED to LAST 6 MONTHS or MORE?</b>
<i>**Refer to 'Current Intervention Reference Table' above for more information on 'Current Intervention' dropdown options.</i>			
Cutting or Burning or Strangulating Oneself	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting Oneself Severely	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tearing At or Out Body Parts	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inserting Harmful Objects Into Body Orifices	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Aggressive or Offensive Behaviors</b>			
Verbal Abuse	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hitting, Biting, Kicking	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masturbating In Public	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinating on Another or Smearing Feces	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No

BEHAVIOR	FREQUENCY (over the past 6 months)	CURRENT INTERVENTION	EXPECTED to LAST 6 MONTHS or MORE?
<i>**Refer to 'Current Intervention Reference Table' above for more information on 'Current Intervention' dropdown options.</i>			
Serious Threats of Violence	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually Inappropriate Behavior Toward Children or Adults	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abuse or Torture of Animals	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Lack Of Behavioral Controls</b>			
Destruction of Property / Vandalism	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stealing, Burglary or Kleptomania within the Community	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (list): _____	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs/Supervision <input type="checkbox"/> Medical/Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>None of the behavioral problems apply at this time.</b>			

***Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)***

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

## Work and 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?

- Yes
- No

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

- Yes
- No

Is child currently attending high school?

- Yes
- No

What year is the child expected to leave school?

Year (yyyy):

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

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

Current Employment Status

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

Employment Interest

- Interested in new job
- Not interested in new job

If Employed, where: (Check all that apply.)

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

Need for Assistance to Work: (Optional for unemployed persons.)

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

## Health Related Services

Medical or Skilled Nursing Needs: (Check all that apply.)		
	Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more	
<input type="checkbox"/> Recurrent cancer Date of Recurrence: _____ (mm/yyyy)	NA	
<input type="checkbox"/> Stage IV cancer Date of Stage IV Diagnosis: _____ (mm/yyyy)	NA	
<input type="checkbox"/> Terminal condition (verified prognosis < 12 months)	NA	
<input type="checkbox"/> Rehabilitation program for brain injury or coma—minimum 15 hours/week	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Unable to turn self in bed or reposition self in wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Ventilator (positive pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP by therapist (does not include behavioral problems) <input type="checkbox"/> Less than 6 sessions/week <input type="checkbox"/> 6 or more sessions/week	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP therapy follow-through: Exercise, sensory stim, stander, serial splinting/casting, braces, orthotics <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than 1 hour/day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Wound, site care or special skin care <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than 1 hour/day	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Place one checkmark per any row that applies.							
HEALTH-RELATED SERVICES NEEDED	Frequency of Help / Services Needed					Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more	
	Independent with task	1 to 3 times/ Month	1 to 3 times/ Week	4 to 7 times/ week	2 or more times a day		
BOWEL or OSTOMY related SKILLED tasks: digital stim, changing wafer, irrigation (does not include site care).						<input type="checkbox"/> Yes	<input type="checkbox"/> No
DIALYSIS: hemodialysis or peritoneal, in home or at clinic.	N/A	N/A				<input type="checkbox"/> Yes	<input type="checkbox"/> No
IVs - peripheral or central lines - fluids, medications, and transfusions (does not include site care).						<input type="checkbox"/> Yes	<input type="checkbox"/> No
OXYGEN and/or deep SUCTIONING - With oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.						<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH-RELATED SERVICES NEEDED	Frequency of Help / Services Needed					Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more	
	Independent with task	1 to 3 times/ Month	1 to 3 times/ Week	4 to 7 times/ week	2 or more times a day		
RESPIRATORY TREATMENTS: Chest PT, C-PAP, Bi-PAP, IPPB treatments (does not include inhalers or nebulizers).						<input type="checkbox"/> Yes	<input type="checkbox"/> No
TPN (Total Parenteral Nutrition) Does not include site care.						<input type="checkbox"/> Yes	<input type="checkbox"/> No
TUBE FEEDINGS (does not include site care).						<input type="checkbox"/> Yes	<input type="checkbox"/> No
URINARY CATHETER-RELATED SKILLED TASKS: straight caths, irrigations, instilling meds (does not include site care).						<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Risk

### Risk Evident During Screening Process: (Check all that apply.)

- No risk factors or evidence of abuse or neglect apparent at this time.

### Parents/caregivers' situation is at risk due to: (Check all that apply.)

- Difficulties in meeting the child's complex medical or health needs
- Difficulties in meeting the child's complex behavioral or mental health needs
- Parent's medical or health needs
- Parent's mental health needs
- Parent's substance abuse needs
- Domestic violence issues
- Involvement with the criminal justice system

### Exacerbation: (Check all that apply.)

- Child's medical symptoms within last 12 months
- Child's behavioral or mental health symptoms within last 12 months

### Other Concerns: (Check all that apply.)

- Behaviors place the child at risk of removal from home (or equivalent residence).
- The child has had a significant increase in the need for assistance in ADLs, IADLs, and/or health-related services over the last 3 months.
- The child has had a significant increase in the need for mental health services, juvenile justice system, in-school supports (for emotional and/or behavioral problems), and/or substance abuse services over the last 3 months.
- There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.
  - If yes:
    - Referring to CPS now
    - Referring to APS now
    - Competent adult refuses to allow referral to APS

Comments:

- The child's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months).

## Functional Disability

This page screens the applicant for an expedited functional disability indicator:

### Information below is based on: (check all that apply)

- Allowable documentation
- Parental report

### Gestational Age and Birth Weight: (choose only one)

- Gestational Age of 37 to 40 weeks and weight at birth < 2,000 grams (4 lbs. 6 oz.)
- Gestational Age of 36 weeks and weight at birth <= 1,875 grams (4 lbs. 2 oz.)
- Gestational Age of 35 weeks and weight at birth <= 1,700 grams (3 lbs. 12 oz.)
- Gestational Age of 34 weeks and weight at birth <= 1,500 grams (3 lbs. 5 oz.)
- Gestational Age of 33 weeks and weight at birth <= 1,325 grams (2 lbs. 15 oz.)
- Any Gestational Age and weight at birth < 1,200 grams (2 lbs. 10 oz.)
- None of the above apply

### Additional Diagnoses: (check all that apply)

- Amputation of a leg at the hip
- Malignant tumors except for brain or thyroid diagnosed within the past 2 years

*Specify:*

- Non-Hodgkin's lymphoma diagnosed within the last 2.5 years

#### **Life-threatening congenital heart disease**

- Coarctation of the aorta
- Complete AV canal defects
- Hypoplastic left heart syndrome
- Multiple ventricular septal defects
- Pulmonary atresia
- Tetralogy of Fallot
- Transposition of the great arteries
- Tricuspid atresia
- Other – Please specify:

#### **Other catastrophic congenital abnormalities**

- Anencephaly
- Cri-du-chat
- Cyclopia
- Tay-Sachs disease
- Trisomy D
- Trisomy E
- Other – Please specify:

The questions below will be dynamically displayed on the functional screen. Please check the boxes that apply to this applicant.

**Blind or severely visually impaired**

- Total blindness expected to last at least 12 months

**Down Syndrome**

- Excluding Mosaic

**TPN (Total Parental Nutrition) does not include site care**

- Expected to last at least 12 months

**Tracheostomy**

- Has already lasted at least 6 months  
 Expected to last for at least 6 months from now

**Tube feedings (does not include site care)**

- Has already lasted at least 6 months  
 Expected to last for at least 6 months from now

**Uses a wheelchair or other mobility device not including a single cane**

- Total duration at least 12 months

**Ventilator (positive pressure)**

- Expected to last at least 12 months

- I have reviewed this page and none of the questions apply to this applicant.

## Screen Completion Time

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

Time to Complete Screen	Hours	Minutes
<b>Face-to-Face Contact with Person</b> This can include an in-person interview, or observation if child cannot participate in interview.		
<b>Collateral Contacts</b> Either in-person or indirect contact with any other people, including other family members, advocates, providers, etc.		
<b>Paper Work</b> Includes review of medical documents, COP assessment, etc		
<b>Travel Time</b>		
<b>Total Time to Complete Screen</b>		

### TRANSFER INFORMATION

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

Referral date to service agency (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Service Agency: \_\_\_\_\_