



AGENCY OF HUMAN SERVICES
CHILDREN'S PERSONAL CARE SERVICES
VERMONT DEPARTMENT OF HEALTH
108 CHERRY STREET; BOX 70
BURLINGTON, VT 05401
888.268.4860

Instructions for completing Integrated Family Services Intake Form for use with VDH Children with Special Health Need supports and the Children's Personal Care Services Functional Ability Screening Tool

- ✓ The Integrated Family Services (IFS) Intake Form should only be used to apply/reapply for select Children with Special Health Needs programs. These services include:
 - ◆ Children with Special Health Needs (CSHN) Enhanced Respite
 - ◆ Children's Personal Care Services (CPCS)
- ✓ IFS Intake Form must be completed by an evaluator who has successfully completed training on both the IFS Intake Form and Children's Personal Care Services Functional Ability Screening Tool (i.e., by an evaluator who is included in the Children's Personal Care Services Assessor Directory)
- ✓ IFS Intake Form can be completed with the family (in person, over the phone, or through collateral contact). Demographic (or intake) portion of the IFS Intake Form can be completed directly by the family in advance. It is *not* appropriate for the family to complete non-demographic portions of the IFS Intake Form directly nor is it appropriate for the family to complete any portion of the Children's Personal Care Services Functional Ability Screening Tool.
- ✓ The child (applicant) must be present—and participate—in the Children's Personal Care Services application process. Applications where the child is not present or does not participate are considered incomplete and cannot be submitted for review. How the child participates may take different forms depending on the child's tolerance level for such activities. **HOWEVER**, it is important to have an opportunity to for the assessor to interact with the child on some level.
- ✓ To apply for Children's Personal Care Services, an IFS Intake Form, Children's Personal Care Services Functional Ability Screen and Children's Personal Care Services Care Plan must be completed. Please include supplemental information—such as Child Development Clinic report, psychological evaluation, Individualized Education Plan/Section 504 Plan, hospital/residential treatment facility discharge plans, physician notes. For new applicants, diagnosis verification must be included.
- ✓ Missing or incomplete information may result in delayed processing, returned application, or a denial of services. Please take care to provide complete and accurate information.
- ✓ Send completed materials to:

**Children's Personal Care Services
c/o Children with Special Health Needs
108 Cherry Street, Box 70
Burlington, VT 05401
Fax: 802.863.7635**

INTEGRATED FAMILY SERVICES INTAKE FORM

A. Demographic Information

1) Basic Information for whom services are being applied			
*First Name <i>Bradley</i>	*Last Name <i>Smith</i>		
*Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Unique Identifier/Medicaid ID # <i>123456</i>	Date of Birth <i>10/3/01</i>	Age <i>13</i>
*Physical Address <i>123 Main Street, Apt. 1</i>			
*City <i>Anytown</i>	*State <i>VT</i>	County <i>Chittenden</i>	*Zip <i>05000</i>
Mailing Address, if different <i>w/a</i>		Primary Diagnosis (including ICD-10) <i>Cerebral Palsy G80.9</i>	
2) Assessor's Name and Organization			
*Name and Organization <i>Jennifer Garabedian, Children with Special Health Needs</i>		*Intake Date <i>6/1/14</i>	
*Mailing Address <i>108 Cherry Street, Box 70</i>		*Telephone Number <i>802.865.1395</i>	
*City <i>Burlington</i>	*State <i>VT</i>	*Zip <i>05401</i>	

3) Referral Source: (Check only one option)	
<input type="checkbox"/> Self/family <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self <input type="checkbox"/> Social Worker <input type="checkbox"/> School/Preschool <input type="checkbox"/> PICU/NICU <input type="checkbox"/> Child Care Provider <input type="checkbox"/> DCF—Family Services	<input type="checkbox"/> Physical Therapist, Occupational Therapist, or Speech Language Pathologist <input type="checkbox"/> Children's Integrated Services (CIS) Team <input type="checkbox"/> Primary/Specialty Care Provider <input type="checkbox"/> Designated Developmental/Mental Health Agency or Specialized Services Agency (please indicate) <input type="checkbox"/> Children's Personal Care Services Re-evaluation Notice <input type="checkbox"/> Other (please specify):
<p>*Primary Concern/Reason for Referral: <i>Mother provides a significant amount of care related to Bradley's personal care. Family has benefited from supports and wish to have CPCS continue</i></p>	

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4)* Is the child in Department of Children and Family—Family Services (DCF) custody?

Yes No If appropriate, DCF is aware of intake/referral?

If yes, Department of Children and Family—Family Services Worker Contact Information

5) Current Residence

- | | |
|--|--|
| <input checked="" type="checkbox"/> With Parent(s) | <input type="checkbox"/> ICF-DD |
| <input type="checkbox"/> Shared Physical Custody between Parents | <input type="checkbox"/> Nursing Home—Rehabilitation Facility |
| <input type="checkbox"/> With Other Unpaid Family Member(s) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> With Legal Guardian | <input type="checkbox"/> In-State Residential Treatment Facility |
| <input type="checkbox"/> Alone (includes person living alone receiving in-home services) | <input type="checkbox"/> Out-of-State Residential Treatment Facility |
| <input type="checkbox"/> DCF-Family Services Foster Care | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Shared Living Provider | <input type="checkbox"/> Juvenile detention/jail |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> With spouse/partner/roommate |
| <input type="checkbox"/> Hospice Care Facility | <input type="checkbox"/> Other (please specify): _____ |

6a) *Parent/Guardian Contact Information (Primary Caregiver)
(If both parents reside at same address, please complete jointly)

- *Relationship (check only one option):**
- | | |
|--|--|
| <input checked="" type="checkbox"/> Parent(s) (Biological) | <input type="checkbox"/> Foster Parent(s) |
| <input type="checkbox"/> Parent(s) (Adopted – complete #9) | <input type="checkbox"/> Shared Living Provider |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Spouse/Partner |
| | <input type="checkbox"/> Other (please specify): _____ |

*First Name

Mary

*Last Name

Johnson-Smith

*Address

Same as above

Mailing Address, if different

*City

*State

*Zip

* Telephone Number(s)

802.555.1234

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6b) Other Adult (Parent/Guardian) Contact Information (Secondary Caregiver)	
Relationship (check only one option):	
<input type="checkbox"/> Parent (Biological)	<input type="checkbox"/> Foster Parent
<input type="checkbox"/> Parent (Adopted – complete #9)	<input type="checkbox"/> Shared Living Provider
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other (please specify): _____
First Name w/a	Last Name
Address	Mailing Address, if different
City	State Zip
Telephone Number(s)	

7) What is the family's primary language? (check only one option)		
<input checked="" type="checkbox"/> English	<input type="checkbox"/> Serbo-Croatian	<input type="checkbox"/> American Sign Language/TTY-Relay Service
<input type="checkbox"/> Arabic	<input type="checkbox"/> Somali	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Burmese	<input type="checkbox"/> Spanish	Does the primary care giver have Limited English Proficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dinka	<input type="checkbox"/> Swahili	Is an interpreter is required? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> French	<input type="checkbox"/> Russian	
<input type="checkbox"/> Napali	<input type="checkbox"/> Vietnamese	

8) Has this child been adopted?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, if yes, when? _____ (year)
Is the family connected with post-adoption services?	<input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, what agency?
<input type="checkbox"/> Is the child/family receiving post-adoption case management? If yes, please indicate organization, case manager and contact number. w/a	
<input type="checkbox"/> Is the family receiving an adoption subsidy? Level of support? w/a	

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B. Household Information

1) Family Composition (list all the people who currently live in your child's home, excluding the child)

<i>First and Last Name</i>	<i>Date of Birth</i>	<i>Sex (M/F)</i>	<i>Relationship to child</i>
Mary Johnson-Smith	11/6/78	F	Mother
Webster Smith	5/30/99	M	Brother

List the parents and/or siblings who do not currently live in your child's home

<i>First and Last Name</i>	<i>Date of Birth</i>	<i>Sex (M/F)</i>	<i>Relationship to child</i>
n/a			

2) Agency of Human Services Indicators

Does the family have:

Safe, secure housing?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Concerns about the child(ren)'s safety Mary is concerned that Bradley can't be left unsupervised	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Active involvement in the criminal justice system?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes

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Agency of Human Services Indicators (cont'd)	
Is the home environment free of abuse, neglect and/or exploitation?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Is the parent interested in information regarding nutrition programs (WIC, 3-Squares, etc.)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Is the parent interested in information related Economic Services program (fuel assistance, ReachUp, etc.)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Do(es) the parent(s) have a primary physician	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Does the parent have any health concerns: <i>Mary has been diagnosed with diabetes. Sometimes she struggles to manage her condition</i>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

Additional Information regarding AHS Indicators

Family recent moved to an accessible apartment—previous home needed substantial work to be accessible

Mom's medical condition is not always well-managed—her health needs can make providing all necessary care for her children challenging at times. Working with new health care provider

3) Narrative regarding family strengths, challenges, and resiliency factors

Bradley's father passed away about 18 months ago—long battle with cancer
Loss has been hard for family—Bradley had a strong relationship with his dad
Dad was a major caregiver for B until he became too ill

Bradley has a great sense of humor and strives to be as independent as possible
Enjoys swimming (has aquatherapy weekly) and watching movies with his brother
Bradley and Webster (Webb) have a good relationship—with typical sibling issues—but tend
to get along. Webb is often a big help to Mary.
B has significant care needs and has not ever been unsupervised. B would like a greater
sense of independence as he gets older and has been testing boundaries

Mom's health concerns and job make juggling her children's needs challenging at times

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C. Health Information for the Child

1) Private Insurance Information (, include policy number and clearly write numbers)		
Company Name & Policy Number Blue Cross Blue Shield	Policy Holder's Name Mary Johnson-Smith	Individual Number 987654321C
Company Name & Policy Number	Policy Holder's Name	Individual Number
2) List the hospitalizations, surgeries or medical procedures (i.e., MRI, CT Scan, EEG) within the last 12-18 months (include supplemental materials as appropriate)		
Date	Location/Provider	Reason for hospitalization or procedure
11/2012	Boston Children's Hospital	Selective dorsal rhizotomy
7/2009-9/2012	FAHC	Botox treatments

Health Care Provider Contact Information (add additional pages as needed)

3) *Medical Home/Primary Physician			
Date of Last Visit: _2/2014_		Date of Next Scheduled Visit: _2/2015_	
*Physician's First Name Pam		*Physician's Last Name Jackson	
*Address (including Group/Practice Name, if applicable) FAHC—353 Blair Park			
*City Williston	*State VT	*Zip 05495	*Telephone Number 802.847.1440

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3a) Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit: <u>3/2014</u>		Date of Next Scheduled Visit: <u>7/2014</u>	
Area of Specialization: <u>Ortho</u>			
First Name <u>Jennifer</u>		Last Name <u>Lisle</u>	
Address (including Group/Practice Name, if applicable) <u>FAHC—192 Tilley Drive</u>			
City <u>So. Burlington</u>	State <u>VT</u>	Zip <u>05403</u>	Telephone Number <u>802.847.4690</u>

Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit: <u>2010?</u>		Date of Next Scheduled Visit: <u>w/a</u>	
Area of Specialization: <u>Pedi Endocrinology</u>			
First Name <u>Martina</u>		Last Name <u>Kacer</u>	
Address (including Group/Practice Name, if applicable) <u>FAHC—11 Colchester Avenue</u>			
City <u>Burlington</u>	State <u>VT</u>	Zip <u>05401</u>	Telephone Number <u>802.847.6200</u>

Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit: <u>1/2014</u>		Date of Next Scheduled Visit: <u>7/2014</u>	
Area of Specialization <u>Physiatry</u>			
Specialist's First Name <u>Scott</u>		Specialist's Last Name <u>Benjamin</u>	
Address (including Group/Practice Name, if applicable) <u>FAHC—790 College Parkway</u>			
City <u>Colchester</u>	State <u>VT</u>	Zip <u>05446</u>	Telephone Number <u>802-847-6846</u>

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D. Skilled Care Needs

1) Health Care Needs Related to:	
	Expected to last for at least 6 months
<input type="checkbox"/> Rehabilitation program for brain injury or coma (minimum of 15 hr/wk)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Wound, site care or special skin care (please specify): <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than 1 hour/day	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
OSTOMY CARE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DIALYSIS (home vs. outpatient)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
OXYGEN dependence and delivery (nasal cannula, CPAP, BiPAP, ventilator)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
URINARY CATHETER	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
IV ACCESS	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MEDICATION MANAGEMENT Must include current medication list and schedule <i>Diazepam—5 mg 3x day</i> <i>Melatonin—6 mg daily</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

E. Emotional and Behavioral Challenges

Pediatric Symptom Checklist-17

1) Does the child experience challenges with attention, such as:			
	Never	Some	Often
Fidgety, unable to sit still	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daydreams too much	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distracted easily	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Has trouble concentrating	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Acts as if driven by a motor	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Does the child:			
	Never	Some	Often
Feel sad, unhappy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Feel hopeless	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is down on him/herself	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worry a lot	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seem to be having less fun	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3) Does the child:			
	Never	Some	Often
Fight with others	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not listen to rules	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Not understand other people's feelings	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tease others	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Blame others for his/her troubles	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refuse to share	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take things that do not belong to him/her	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

Bradley is a mostly happy kid; sometimes feels excluded and sad as a result. He realizes that his condition makes him "different" from other kids. Mom feels that he is open to talking to her about these issues. B also has a strong relationship with his teacher, who Mom has encouraged him to talk with as well.

F. Additional Health Information (add additional pages as needed)

Additional information related to the child's recent health status (within the last 12-18 months), including any hospitalizations or rehabilitative placements. Please include previous screens or evaluations performed.

Bradley's health has been pretty stable in the last 2 years; previously received Botox treatments to address the spasticity he experiences. When it was determined these injections weren't helping much, family opted for surgery. B also takes daily meds to help with control the spasticity

Historically, B hasn't slept well. He currently takes melatonin (extended release) which has helped with this issue. Occasionally, Bradley will have a period where he doesn't sleep much (disrupted sleep-- up in the overnight)—which can last for days. Bradley tends to experience increased issues with toileting during these cycles.

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G. Supports Information for the Child

	<i>Previously Received</i>	<i>Currently Receiving</i>
HEALTH SERVICES		
Pediatrician/Primary Care Physician (Medical Home Practice)		✓
Dentist		✓
Physical Therapy		✓
Occupational Therapy		✓
Speech/language Therapy		
Home Health Services	✓	
Nutrition Support		
Hearing Support		
Vision Support (Division for Blind and Visually Impaired Services)	✓	
Communication Support		
Service Coordination/Case Management (please specific provider) <input type="checkbox"/> Medical Home <input type="checkbox"/> Children's Mental Health/Developmental Services <input type="checkbox"/> Home Health Agency <input checked="" type="checkbox"/> Vermont Department of Health—Children with Special Health Needs Roz LaVallee		✓
Other:		

Is the child actively enrolled in school (including private, alternative and home schooling)?
 Yes, if yes, what grade?
 No

School Name, City, State
Burlington High School, Burlington, VT

School Case Manager's Name (or Teacher, if appropriate) and Telephone Number
Rich Richardson 802-555-4567

Is child's school attendance significantly affected (i.e., misses at least 50% of school, has an alternate school day or has home tutoring) by his/her condition(s)?
 No Yes, if yes, please indicate how **Bradley doesn't miss many days of school but has accommodations**

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	Previously Received	Currently Receiving
EDUCATION SERVICES (Agency of Education)		
Early Essential Education (EEE)	✓	
Section 504 Plan		✓
Individual Education Plan (IEP) (Special Education)	✓	
Coordinated Services Plan (Act 264 Plan)		
IEP Transition Plan		
Division of Voc. Rehabilitation		
Other:		
OUT-OF-SCHOOL TIME SERVICES (School-age Children/youth)		
After School Services/Tutor		✓
Child Care <input type="checkbox"/> DCF Subsidized <input type="checkbox"/> CDD- Accommodations Grant Summer and/or School Vacation Camps		
Other:		
CHILDREN'S INTEGRATED SERVICES-EARLY CHILDHOOD (CIS-EI) (Department for Children and Families)		
Children's Integrated Services (ages 0-6)	✓	
Child Care/Early Childhood Program/Pre-school <input type="checkbox"/> DCF Subsidized <input checked="" type="checkbox"/> CDD- Accommodations Grant	✓	
Early Head Start		
Head Start		
Other:		

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	Previously Received	Currently Receiving
CHILDREN WITH SPECIAL HEALTH NEEDS (Vermont Department of Health)		
Children with Special Health Needs Care Coordinator/Contact: <i>Roz Lavallee (contact as needed)</i>		✓
<input checked="" type="checkbox"/> Respite (annual allocation): \$ <u>600.00</u>		✓
<input checked="" type="checkbox"/> Child Development Clinic (Date): <u>5/2004</u>		✓
<input type="checkbox"/> Cleft Palate Clinic		
<input checked="" type="checkbox"/> Physiatry Clinic		
<input type="checkbox"/> CF Clinic		
Children's Personal Care Services <input type="checkbox"/> New Application <input type="checkbox"/> Current Allocation/Level:		✓
High-Technology Home Care <input type="checkbox"/> Level of Service Authorized:		
Pediatric Palliative Care Program (in conjunction with DVHA)		
Other:		

	Previously Received	Currently Receiving
COMMUNITY MENTAL HEALTH AND/OR DEVELOPMENTAL DISABILITY SERVICES SUPPORTS (Department of Mental Health and Department of Disabilities, Aging and Independent Living)		
School Based Clinician/Home-School Coordination		
Individual Therapy		
Family Therapy	<i>n/a</i>	
Group Therapy		
Behavioral Services/consultation		
Autism Services		
Psychiatric Services (Medication Management)		
Crisis Services		

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	<i>Previously Received</i>	<i>Currently Receiving</i>
COMMUNITY MENTAL HEALTH AND/OR DEVELOPMENTAL DISABILITY SERVICES SUPPORTS (cont'd) (Department of Mental Health and Department of Disabilities, Aging and Independent Living)		
Intensive Family Based Services		
Traumatic Brain Injury Supports		
Respite		w/a
Community Supports		
Flexible Family Funding: <input type="checkbox"/> Waiting List <input type="checkbox"/> Annual Level of Funding:		
Home Modifications		
Other (please specify):		

Is there a need for assistance/support to access any of the above services? Either services the child is currently receiving or services the child might benefit from access to? If yes, please indicate which service(s)

Family is interested in exploring DS eligibility—related to future planning.
B would like to have more integrated group activities—has participated in Partners in Adventure/VASS but wants to be with classmates and friends

May want to consider counseling/therapy to address some of the sadness that B is experiencing as he gets older and is more aware of his "difference"/challenges he is facing

H. Description of Direct Evaluation

Provide a brief description of your interaction/evaluation of this child for these supports. Please provide as much detail as possible related to your interaction and the child's participation.

I met with Mary to complete the intake and parental report section of the application.

Bradley was outdoors with his brother, while she and I spoke. I joined Bradley outside after.

He showed me a drawing that he had been working on and we spoke about what he was planning to do over the summer. Bradley is pretty excited about a day camp that he'll be repeat attending—he is looking forward to fishing and boating. Multiple times, I had to ask him to himself.

During my visit, I observed Webb providing assistance for Bradley to use the bathroom. Webb went into the bathroom to assist his brother—Mary checked verbally to be sure everything was okay.

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I. Signature Page and Consent for Information Sharing

Assessor and Parent Signature

Parent/Guardian:

I acknowledge that the Children's Personal Care Services application—including Integrated Family Services Intake, Functional Ability Screening Tool and Care Plan—was performed with input provided by me and direct interaction with my child.

Mary Johnson-Smith

6/1/2014

Parent/Guardian Signature

Date

Assessor:

I acknowledge that I completed Children's Personal Care Services application—including Integrated Family Services Intake, Functional Ability Screening Tool and Care Plan, with input from the parent/guardian and direct interaction with the child.

Jennifer Garabedian

6/1/2014

Assessor Signature

Date

Consent for Information Sharing—within Agency of Human Services

By signing this form, I authorize and give my permission to allow disclosure:

OF INFORMATION obtained by me in the course of applying for and/or receiving services or benefits through the Agency of Human Services (AHS)

FROM a staff person on an AHS department, division

TO a staff person of another AHS department, division

FOR THE PURPOSES OF:

- Determining eligibility for services or benefits
- Providing services or benefits to the fullest extent and most efficient manner
- Ensuring that services provided by AHS are coordinated and not duplicated
- Avoiding repetitive and unnecessary paperwork

You do not have to sign this form. If you chose not to sign, any benefit to which you/your child is entitled will not be affected. However, by not giving authorization to share information, you may not be able to participate in certain services to the fullest extent and as efficiently as possible.

By signing the form, I understand:

- 1) The reason(s) I am being asked to authorize the release of information
- 2) That only information that is relevant to my application for or receipt of AHS services or benefits shall be disclosed, and only to the minimum extent necessary to accomplish the purposes identified above.
- 3) That AHS departments and division may legally share most of the personal information they have about me on a need to know basis. However, state and federal laws do restrict sharing of certain types of information, absent my authorization.
- 4) That I am authorizing AHS department and divisions to communication to disclose to one another personal information, when relevant, that otherwise could not be shared under state and federal law as referenced above.
- 5) While AHS takes every precaution to protect my health and other personal information, one it is disclose pursuant to this authorization, it may be subject to re-disclosure.
- 6) The re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status, without consent, is prohibited by law. By signing this form, I authorize the initial disclosure of such information, if applicable, as well as any subsequent disclosure among AHS departments and divisions.
- 7) By checking the box below, I signify that I have **not** consented to the re-disclosure of such information:
 - I do not consent to re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status.
- 8) I may revoke this authorization at any time by contacting: **Children's Personal Care Services at 800.660.4427**, except to the extent that it has been acted upon.
- 9) If I do not revoke or update the authorization, it will be in effect as long as I am receiving AHS services or benefits.
- 10) I will be provided a copy of this information

Applicant's Initials: *BS*

Date of Birth: *10/3/2001*

Intake Date: *6/1/2014*

If you have questions about this form, please contact Children's Personal Care Services by calling 800.660.4427.

Mary Johnson-Smith

6/1/2014

Signature of Individual or Parent/Legal Representative

Date

Mother

Relationship to Beneficiary

Jennifer Garabedian

6/1/2014

Signature of Assessor/Individual Explaining Authorization

Date

Jennifer Garabedian

Name

Children with Special Health Needs/CPCS

Organization

Consent for Information Sharing—between AHS and Designated Agency

By signing this form, I authorize and give my permission to allow disclosure:

OF INFORMATION obtained by me in the course of applying for and/or receiving services or benefits through the Agency of Human Services (AHS) or Designated Agency (DA)

FROM an AHS staff person

TO a staff person of a designated agency

FROM a staff person of a designated agency

TO an AHS staff person

FOR THE PURPOSES OF:

- Determining eligibility for services or benefits
- Providing services or benefits to the fullest extent and most efficient manner
- Ensuring that services provided are coordinated and not duplicated
- Avoiding repetitive and unnecessary paperwork

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By signing the form, I understand:

- 1) The reason(s) I am being asked to authorize the release of information
- 2) That only information that is relevant to my application for or receipt of AHS or DA services or benefits shall be disclosed, and only to the minimum extent necessary to accomplish the purposes identified above.
- 3) That AHS and the DA may legally share most of the personal information they have about me on a need to know basis. However, state and federal laws do restrict sharing of certain types of information, absent my authorization.
- 4) That I am authorizing AHS and the DA to communicate to one another personal information, when relevant, that otherwise could not be shared under state and federal law as referenced above.
- 5) While AHS and the DA takes every precaution to protect my health and other personal information, once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- 6) The re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status, without consent, is prohibited by law. By signing this form, I authorize the initial disclosure of such information, if applicable, as well as any subsequent disclosure among AHS departments and divisions and the DA.
- 7) By checking the box below, I signify that I have **not** consented to the re-disclosure of such information:
 - I do not consent to re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status.

Applicant's Initials: *BS*

Date of Birth: *10/3/2001*

Intake Date: *6/1/2014*

- 8) I may revoke this authorization at any time by contacting: **Children's Personal Care Services** at **800.660.4427**, except to the extent that it has been acted upon.
- 9) If I do not revoke or update the authorization, it will be in effect as long as I am receiving services or benefits.
- 10) I will be provided a copy of this information

If you have questions about this form, please contact **Children's Personal Care Services** by calling **800.660.4427**.

Mary Johnson-Smith

6/1/2014

Signature of Individual or Parent/Legal Representative

Date

Mother

Relationship to Beneficiary

Jennifer Garabedian

6/1/2014

Signature of Assessor/Individual Explaining Authorization

Date

Jennifer Garabedian

Name

Children with Special Health Needs/CPCS

Organization

Applicant's Initials: BS

Date of Birth: 10/3/2001

Intake Date: 6/1/2014

Consent for Information Sharing—between AHS and Health Care Providers

I hereby authorize:

- All health care providers listed in this document
- The following providers:

to disclose to the Vermont Department of Health, Children with Special Health Needs (CSHN) pertinent medical, educations, social or mental health records, X-rays, and/or screening reports **for the purpose of determining medical necessity for Children's Personal Care Services regarding this applicant.**

Eligibility for Children's Personal Care Services is not conditioned upon my authorizing this disclosure. Further, I may revoke this authorization at any time except to the extent that CSHN has already acted in reliance of it. In general, revocation must be submitted in writing and sent to CSHN/CPCS at this address:

Vermont Department of Health
Children with Special Health Needs
108 Cherry Street, Box 70
Burlington, VT 05401
Attn: Children's Personal Care Services

Means of disclosure (check all that apply):

- written
- oral
- electronic
- audio tape

Date upon which this authorization will expire: / / (mm/dd/yyyy). If no date is noted, expiration is three (3) years from the date it is signed.

Mary Johnson-Smith

6/1/2014

Signature of Individual or Parent/Legal Guardian

Mary Johnson-Smith

Date

Printed Name

Mother

Relationship to Beneficiary

Witness (age 18 or older):

Jennifer Garabedian

CPCS Administrator

Signature and Title

Date: 6/1/2014

Applicant's Initials: **BS**

Date of Birth: **10/3/2001**

Intake Date: **6/1/2014**

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature of Individual or Parent/Legal Guardian

SAMPLE

Child's Name: *Bradley Smith*

Child's DOB: *10/3/01*

Screeener's Name *Jennifer Garabedian*

Screen Date: *6/1/14*

Children's Personal Care Services—Functional Ability Screening Tool

Age Cohort: 12 years-14 years

Activities of Daily Living Section:

Choose only ONE response—the most representative need in each area. Choosing multiple responses may delay the final determination and/or result in the Functional Ability Screen returned. Please provide additional detail/comments to describe strengths and need.

BATHING: The ability to shower or bathe—does not include hair care. Does include the ability to get in or out of the tub, turn faucets on &/or off, regulate temperature & fully wash & dry. (Mark only one choice)

- Needs adaptive equipment
- Is combative during bathing (e.g., flails, takes 2 caregivers to accomplish task)
- Needs physical help with bathing tasks
- Needs to be lifted in and out of bathtub or shower
- Needs step-by-step cueing to complete the task
- Lacks an understanding of risk and must be supervised for safety
- Exhibits non-compliant behavior that is extreme to point that child does not perform bathing tasks for at least 5 or more consecutive days
- None of the above apply

Is the bathing functional impairment expected to last for at least one year from the date of screening?

- Y
- N

Notes:

Requires full assistance to bathe—tried to help wash arms and stomach. Mother uses bath chair as Bradley can't sit unsupported

GROOMING: Brushing teeth, washing hands & face. Due to variation in hair care by culture, length of hair, etc., hair care is NOT considered. (Mark only one choice)

- Is combative during grooming (e.g., flails, clamps mouth shut, takes 2 caregivers to accomplish task)
- Needs physical help with grooming tasks
- Needs step-by-step cueing to complete the task
- Exhibits non-compliant behavior that is extreme to point that child does not perform does not brush their teeth for at least 5 or more consecutive days
- None of the above apply

Is the grooming (brushing teeth, washing hands and face) functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Mom brushes teeth and hair; can wash hands but cannot dry them. Cannot manipulate faucets

DRESSING: The ability to dress as necessary; does not include the fine motor coordination for fasteners. (Mark only one choice)

- Needs physical assistance with getting clothes on. This does **NOT** include fasteners such as buttons, zippers and snaps.
- None of the above apply
⇒ If, "none of the above apply", is the most accurate response, please complete the Supplemental Screening Questionnaire related to Dressing on page 5

Is the dressing functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Spasticity compromises ability to participate. Mom must dress, but Bradley can choose clothing

EATING: The ability to eat & drink by finger feeding or using routine &/or adaptive utensils; includes ability to swallow sufficiently to obtain adequate intake. Does **NOT** include cooking food or meal set-up. (Mark only one choice)

- Receives tube feedings or TPN
- Needs to be fed
- Needs one-on-one monitoring to prevent choking, aspiration, or other serious complication
- None of the above apply

Is the eating functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Eats wide variety of foods. Food must be cut up but can feed self. Needs support with drinks—uses a straw because can't lift cup.

TOILETING: The ability to use a toilet or urinal, transferring on/off a toilet & pulling down/up pants. Does **not** include behavioral challenges involving voiding &/or defecating. (Mark only one choice)

- Incontinent of bowel and/or bladder
- Needs physical help, step-by-step cues, or toileting schedule
- None of the above apply

Is the toileting functional impairment(s) expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Needs full assistance to use bathroom—can indicate need. Rarely has daytime accidents, but occasionally does happen (2-3 times per month)

MOBILITY: The ability to move between locations within environments, including home, school & the community. This includes walking, crawling & wheeling oneself. (Mark only one choice)

- Does not walk or needs physical help to walk
⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Mobility on page 6
- Uses wheelchair or other mobility device as primary method of mobility not including a single cane
⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Mobility on page 6
- None of the above apply

Is the mobility functional impairment checked expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

TRANSFERS: The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. Does NOT include transfer into bathtub or shower, on/off toilet, or in/out of vehicle. Does NOT refer to a child's challenges related to *transitions*. (Mark only one choice)

- Needs physical help with transfers
⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Transfers on page 5
- Uses a mechanical lift
- None of the above apply

Is the transfers (does not include bathtub or shower) functional impairment expected to last for at least one year from the date of this screening?

- Y
- N

Notes: *Bradley and his family look to maximize his participation in personal care. This can result in additional time needed to perform ADLs*

⇒ If directed by specific responses within a domain, go to pages 4-5 to complete all applicable sections of Supplemental Screening Questionnaire.

If Supplemental Screening Questionnaire is not applicable, skip to page 6 to return to Functional Ability Screening Tool to complete Instrumental Activities of Daily Living portion.

Child's Name: *Bradley Smith*

Child's DOB: *10/3/01*

Screen Date: *6/1/14*

Children's Personal Care Services—Supplemental Screening Questionnaire

Age Cohort: 12 years-14 years

*To be completed to provide additional information related to previous responses in ADL section of the Functional Ability Screening Tool. Respond **only** to these additional questions if prompted to within the Functional Ability Screen.*

DRESSING: The ability to dress as necessary; does not include the fine motor coordination for fasteners.

If, "none of the above apply", was selected, is the child's need best described as:
Needs step-by-step cueing to complete the task?

- Y
 N

If no, specify child's individual needs/challenges below

Notes:

MOBILITY: The ability to move between locations within environments, including home, school & the community. This includes walking, crawling & wheeling oneself.

If "uses wheelchair or other mobility device as primary method of mobility (not including a single cane)" was selected, does the child:

- Self-propel manual wheelchair for primary mobility
- Drive power wheelchair for primary mobility
- Require extensive assistance to operate the wheelchair and/or device

If "does not walk or needs physical help to work" was selected, does the child:
Walk with assistance for primary mobility?

- Y
- N

If yes, what method and level of support does the child require:

Method:

- Hand held
- Cane
- Walker
- Crutches
- Orthotics
- Other (must specify):

Level of Support:

- Supervision
- Minimal Assist
- Moderate Assist

If the child does not walk with assistance, please specific child's individual needs/challenges below.

Notes:

Bradley cannot open doors for self

TRANSFERS: The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. Does **NOT** include transfer into bathtub or shower, on/off toilet, or in/out of vehicle. Does **NOT** refer to a child's challenges related to *transitions*.

If "requires physical assistance to transfer; child is able to bear weight and pivot" was selected to best describes the child's need:

Can the method and level of support be described as (please choose only one in each category)?

Method:

- Stand pivot
- Lateral
- Sliding board
- Other (must specify):

Level of Support:

- Supervision
- Minimal Assist
- Moderate Assist

If "requires complete physical assistance to transfer" was selected, is the assistance the child receives:

- One-person
- Two-person
- Mechanical lift
- Other (must specify):

Notes:

Bradley is small for his age and can be transferred with the assistance of only one person. This may change as he gets heavier

⇒Return to Functional Ability Screening Tool to complete Instrumental Activities of Daily Living Section

Children's Personal Care Services—Functional Ability Screening Tool

Age Cohort: 12 years-14 years

Instrumental Activities of Daily Living Section:

Categories included below provide information included in determining appropriateness of Children's Personal Care Services, as well as for screening and referral determination for other Integrated Family Services supports.

Choose as many options as apply. Please provide additional detail/comments to describe strengths and needs.

COMMUNICATION:

- A norm-referenced assessment in receptive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ___/___/___ (mm/dd/yyyy)

Assessment Tool: _____

See list of "Norm-Referenced Assessment Tools for Communication and Growth and Development"

- Within normal limits
- Less than 30% delay
- Greater than or equal to 30% delay
- Less than 2 Standard Deviations (SD) below the norm
- Greater than or equal to 2 Standard Deviations (SD) below the norm

- A norm-referenced assessment in expressive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ___/___/___ (mm/dd/yyyy)

Assessment Tool: _____

See list of "Norm-Referenced Assessment Tools for Communication and Growth and Development"

- Within normal limits
- Less than 30% delay
- Greater than or equal to 30% delay
- Less than 2 Standard Deviations (SD) below the norm
- Greater than or equal to 2 Standard Deviations (SD) below the norm

COMMUNICATION (cont'd):

- Does not follow 3-step instructions that are related and are not routine
- Does not follow 2 single-step instructions given at the same time that are unrelated and not routine
- Does not use language to share information other than basic needs or wants
- Is not understood by familiar people that have infrequent contact with the child
- None of the above apply

Is this communication functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Bradley speaks softly; can be hard for new people to understand him

LEARNING:

- Has a valid full-scale IQ (a substantial functional impairment is defined by a full-scale IQ of 75 or less)

IQ Test: _____ Score: _____

- A norm-referenced assessment in expressive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ___ / ___ / _____ (mm/dd/yyyy)

Assessment Tool:

See list of "Norm-Referenced Assessment Tools for Communication and Growth and Development"

- Within normal limits
- Less than 30% delay
- Greater than or equal to 30% delay
- Less than 2 Standard Deviations (SD) below the norm
- Greater than or equal to 2 Standard Deviations (SD) below the norm

LEARNING (cont'd):

- Is two or more grade levels behind in two academic subjects
- Cannot provide primary address
- Cannot make change from a dollar
- Requires supervision due to inability to problem solve routine issues
- Does not use time to follow a schedule
- None of the above apply

Is the learning functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Has modified schedule at school to accommodate Bradley's needs

SOCIAL COMPETENCY:

- Does not maintain a friendship with at least one person**
Does not demonstrate the interpersonal give-and-take necessary to keep a friendship
- Does not express an interest in spending time with similar aged peers**
Isolates himself/herself from peer
- Does not show concern from the feelings of friends**
Does not notice another person's feelings and offer care or comfort
- None of the above apply

Is the social competency functional impairment expected to last for at least one year from the date of the screening?

- Y
- N

Notes:

Bradley has friendships with a few kids—but his circle is limited. Has a great sense of humor and engages easily with others. Has not really ever been unsupervised but strives to maximize his independence

Integrated Family Services Care Plan

Child's Name: *Bradley Smith*

Date of Birth: *10/3/01*

Assessor's Name: *Jennifer Garabedian*

Screen Date: *6/1/14*

Children's Personal Care Services Goals:

(must include at least one goal related to activities of daily living)

ADL Domain: <i>dressing, bathing, grooming, mobility, toileting, feeding</i>	Goal:	Strengths/Assets to Implement Goal:	Needs/Concerns to Implementing Goal:	Natural Supports Available:
1) <i>Toileting assistance</i>	<i>Ensuring that B's toileting needs are met safely</i>	<i>B is cooperative and motivated</i>	<i>As B gets bigger, one person might not be enough</i>	<i>Mother and older brother</i>
2) <i>Dressing</i>	<i>Help B dress, encourage him to make own choices</i>	<i>B wants to maximize independence</i>	<i>↓</i>	<i>↓</i>
3)				
4)				

Integrated Family Services Goals:

Support Goal:	Strengths/Assets to Implement Goal:	Needs/Concerns to Implementing Goal:	Natural Supports Available:
1) <i>Address some of the "sadness" B experiences</i>	<i>Strong relationship with school team</i>	<i>B has experienced a recent loss in addition to feeling "different"</i>	<i>Mom and brother</i>
2)			
3)			

Parent/Guardian: *I acknowledge that the CPCS Care Plan was created with my input.*

Mary Johnson-Smith

Parent/Guardian Signature

6/1/14

Date

Assessor: *I acknowledge that I completed the CPCS Care Plan with input from the parent/guardian*

Jennifer Garabedian

Screening Signature

6/1/14

Date