

MaineCare Section 24: Day Habilitation Services

Home and Community Based Services For Children with Mental Retardation or Pervasive Developmental Disorders

COMPREHENSIVE ASSESSMENT: A Guide to Conversation



State of Maine
Department of Health and Human Services
Office of Child and Family Services
Children's Behavioral Health Services

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

INTRODUCTION

This comprehensive assessment has been developed for MaineCare Section 24, Day Habilitation Services, by the Department of Health and Human Services Children's Behavioral Health Services in cooperation with parents and providers. The purpose of this tool is to provide a standard format for a conversation between parent and provider that will assist parents in describing their child in a way that providers can better identify the child's strengths and needs in order to provide more individualized services.

The parent provides the information for the comprehensive assessment. The provider also learns about the child from other people in the child's life (i.e. collateral contacts) such as relatives, friends, teachers, daycare provider, or others as may be applicable. Over time the provider's own observations will add to their understanding of the child's strengths and needs and assist in developing an appropriate, individualized plan to deliver Day Habilitation Services.

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Table of Contents

Signature Page	4
Identifying & Background Information	5
Social Functioning	15
Behavioral Functioning	20
Functional Life Skills - Activities of Daily Living	22
Functional Life Skills - Independent Living	27

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

SIGNATURE PAGE

Please have the child/youth and the parent(s) sign the assessment once the conversations process is complete. The Section 24 Agency provider who completed the assessment should also sign below.

PARENT/CAREGIVER:

I talked with _____ from
Agency Person

_____ to help the agency learn
Agency

about my child _____. We talked about his/her strengths, needs, likes, dislikes, history and other important information. This information will help the agency better serve my child. I think this comprehensive assessment is a fair representation of what I said. I understand I can add information to this at any time.

Parent/Guardian

Date

Child/Youth

Date

FOR PROVIDER USE ONLY

Comprehensive Assessment completed by:

Name

Title

Date

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

IDENTIFYING INFORMATION

This is basic demographic information for the agency. This information is given to the agency by Central Enrollment.

Child/Youth Name: _____ DOB: __/__/__ Age: ____ Gender: ____

MaineCare#: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Primary DSM-IV-TR Diagnosis Name & Code:

Axis I: _____ Date of Diagnosis: __/__/__

Axis II: _____ Date of Diagnosis: __/__/__

Axis III: _____ Date of Diagnosis: __/__/__

Axis IV: _____ Date of Diagnosis: __/__/__

Axis V: C-GAS score: _____ Date: __/__/__

IQ Score: _____

Adaptive Functioning Score: _____

Strengths:

Interests:

Reason for Referral:

Presenting Problem(s):

Name of Staff Completing Assessment: _____

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Start Date: __/__/__ End Date: __/__/__

CONTACT LIST

Central Enrollment will provide information about the parents/guardians. Additional information will be collected during the first contact with the family. Complete *Release of Information* as needed for the people listed below.

Mother: _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) *Release Expires:* __/__/__

Father: _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) *Release Expires:* __/__/__

Guardian (if not parent): _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) *Release Expires:* __/__/__

Other Parenting Figure (e.g. foster parent, kin, etc.): _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) *Release Expires:* __/__/__

Extended Family Member(s):

1. Name: _____

Address: _____ Phone: _____

Email: _____

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Release completed? (Check when complete) Release Expires: ___/___/___

2. Name: _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) Release Expires: ___/___/___

Siblings:

Name	Age	Live with child?	Release complete?	Release Expiration
		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	/ /
		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	/ /
		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	/ /
		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	/ /
		Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	/ /

NATURAL SUPPORTS

This is an IMPORTANT PART OF THE ASSESSMENT PROCESS. Information collected here is about the people in the child and family's life who they rely on for material (food, household items, et.), social, emotional and spiritual support. Complete *Release of Information* as needed for the people listed below.

Name: _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) Release Expires: ___/___/___

Name: _____

Address: _____ Phone: _____

Email: _____

Release completed? (Check when complete) Release Expires: ___/___/___

Name: _____

Address: _____ Phone: _____

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Email: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

SERVICES

In this section other services the child is receiving are listed. It is also important to learn from the parent/guardian how the services are working. Services the parent/guardian is receiving can be listed in the comment section. Complete *Release of Information* as needed for the people listed below.

Case Manager: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Case Management Agency: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Primary Care Doctor: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Other Doctor: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Occupational Therapist: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Physical Therapist: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Speech/Language Therapist: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Mental Health Therapist: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

School: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Name of Teacher: _____ Grade Level: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Childcare Provider: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Release completed? (Check when complete) *Release Expires:* ___/___/___

Other: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Release completed? (Check when complete) Release Expires: ___/___/___

MEDICAL

This information is very important to have accurately documented and continuously updated. The worker must have a clear understanding of how to respond to any medical concerns that may occur while working with the child.

Health No Concerns Concerns
Explain:

Hearing No Concerns Concerns
Explain:

Vision No Concerns Concerns
Explain:

Dental No Concerns Concerns
Explain:

Medications			
Name	Purpose	Dose	Frequency

Weight
Do you have any concerns about your child's weight? Yes No
Explain:

Eating Habits
Do you have any concerns about your child's eating habits? Yes No
Explain:

Sleep
Do you have concerns about your child's sleep patterns? Yes No
Has there been a recent change in the child's sleep pattern? Yes No

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Does your child:

- Sleep through the night? Yes No
- Have nightmares? Yes No
- Take naps? Yes No

Explain any sleep concerns:

Physical Complaints:

Does your child have:

- Frequent headaches? Yes No
- Frequent stomach aches? Yes No
- Frequent muscle pain? Yes No
- Frequent itching? Yes No

What else is important to you about your child's medical history?

Do you have other concerns about your child's health? Yes No

If yes, please explain:

Mood/Temperament

Most of the time, would you describe your child's mood as:

Happy Sad Angry Anxious Flat (i.e. very little or no emotion)

How would you describe your child's:

- Activity Level: High Moderate Low
- Emotional Reactions: Strong Moderate Minimal
- Emotional Recovery Time: Long Average Short

Would you describe your child as:

- | | Yes | No |
|----------------|--------------------------|--------------------------|
| • Affectionate | <input type="checkbox"/> | <input type="checkbox"/> |
| • Co-operative | <input type="checkbox"/> | <input type="checkbox"/> |
| • Patient | <input type="checkbox"/> | <input type="checkbox"/> |

If no to any of the above, please explain:

What else is important to you about your child's mood/temperament?

Area of Strength:

Area of Concern:

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

EMERGENCY CONTACTS

Child/Youth: _____ Date: _____

MaineCare #: _____ DOB: ____/____/____
Age: _____

Emergency Contact When Parent is Unavailable		
1. Name:		Relationship to Child:
Address:		
Home phone:	Work phone:	Cell phone:
2. Name:		Relationship to Child:
Address:		
Home phone:	Work phone:	Cell phone:

Who can the worker leave your child with?

Who can come and take care of your child?

If the agency cannot contact anyone on the emergency contact list, this agency will contact:

What does your family define as an emergency?

Who does the worker call when there is an emergency involving an:

Allergy: _____

Seizure: _____

Accident: _____

Other: _____

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

CHILD DEVELOPMENTAL HISTORY

It is important to collect information on early childhood experiences that have a direct impact on this service.

Developmental History: Known Unknown

Developmental Milestones:	Normal Limits	Delay	Unknown
Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Information:

What else is important to you about your child's developmental history?

CHILD CARE

It is important to know how and where your child spends his/her time. If the child does not participate in childcare, skip to education section.

Does your child attend a child-care program? Yes No

How would you describe your experience with childcare?
Good Satisfactory Have Concerns

Explain:

Child Care schedule (please note the time your child is in child care each day per week):

M _____ T _____ W _____ Th _____
F _____ S _____ Su _____

Please list the activities (e.g. board games, physical games, drawing/painting, listening to stories, etc) your child participates in at the child-care program:

What else is important to you about your child's child care?

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

EDUCATION

The information collected in this section is about your child's current educational situation. This information is important for the supervisor to understand so your child's ITP is consistent with his/her education situation. The BHP should also understand how your child learns so that the work s/he does is based on your child's learning style. Skip preschool if child is school age

Preschool

Does your child attend a preschool program? Yes No

Is your child involved with Child Development Services? Yes No

Is your child participating in an educational group experience? Yes No

If yes to above, please specify:

Head Start Nursery School Private School Other

School-Age Children (K-12)

Type of school program: Home Schooled Public School Private School

Grade level (circle one): K 1 2 3 4 5 6 7 8 9 10 11 12

School Schedule: M _____ T _____ W _____

Th _____ F _____ S _____

Su _____

Does child receive Special Education services? Yes No

If yes, please specify the Special Education services currently received:

Mainstreamed class

1:1 in regular classroom

Resource Room

Self-contained classroom

Other Please specify: _____

Explain any Special Education Services/Supports currently received:

What else is important to you about your child's education?

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

VOCATIONAL

This section is only for youth **18 – 20 years old**. The information collected here is about your child's VOCATIONAL TRAINING. This information is important for the supervisor to understand so your child's ITP is consistent with the vocational goals. Day Habilitation Services cannot provide direct vocational training.

Does your child express a desire to work? Yes No

What types of work is your child interested in? _____

What services/support would it take to prepare your child to hold a job?

What else is important to you about your child's vocational training?

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

SOCIAL FUNCTIONING

This section pertains to children of all ages. The information gathered in this section will be directly connected to the Individual Treatment Plan (ITP). The purpose is to gather specific information about the child's ability to interact with others. In areas that are a concern the supervisor should be able to identify the following:

- o The social challenge(s) for the child and family
- o The circumstances in which there are social limitations
- o The circumstances in which there are social competencies
- o The social skills your child is currently able to perform
- o The social skills your child needs to be able to perform

Keeping in mind the child's developmental level and the family's cultural context, use the following to learn about the parent's perceptions of their child's self-awareness.

Self-Awareness

Does your child:

	Most of the time	Sometimes	Never
Identify feelings (sad, glad, mad, hurt, scared)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notice the responses of others to his/her behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notice the responses of others to his/her statements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify two or more things he/she is interested in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify one thing he/she would like to improve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify rewards for him/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What else is important to you about your child's self-awareness?

Area of Strength:

Area of Concern:

Empathy

Does your child:

	Most of the time	Sometimes	Never
Use words or signs to identify others feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk about how others might feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk about what others might say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respond to others feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify one thing he/she would like to improve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify rewards for him/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Is your child:

	Most of the time	Sometimes	Never
Flexible in interactions when relating to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What else is important to you about your child's empathy?

Area of Strength:

Area of Concern:

Managing Emotions

Does your child:

	Most of the time	Sometimes	Never
Use words or age appropriate expressions of feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask for help when experiencing strong feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-soothe when hurt, angry, sad, frightened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tell others how s/he feels about their behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tolerate criticism?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem-solve in challenging situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage disagreement with compromise or negotiation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What kinds of things soothe your child?

What else is important to you about your child's managing emotions?

Area of Strength:

Area of Concern:

Non-Verbal Relationship Skills

Does your child:

	Most of the time	Sometimes	Never
Set personal physical boundaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respect personal physical boundaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use non-verbal communication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respond to non-verbal communication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain age appropriate eye contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjust behavior to fit into new situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

What else is important to you about your child's non-verbal relationship skills?

Area of Strength:

Area of Concern:

Social Interactions

Does your child:

	Most of the time	Sometimes	Never
Introduce self to new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Start a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Introduce appropriate topics in conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask for help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
End a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enter a group appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leave a group appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What else is important to you about your child's social interactions skills?

Area of Strength:

Area of Concern:

Interpersonal

Does your child:

	Most of the time	Sometimes	Never
Give compliments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accept compliments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Share problem with a friend(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give advice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Share objects, ideas, and information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer to help others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admit mistakes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make apologies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Show appropriate interactions with opposite sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

What else is important to you about your child's interpersonal skills?

Area of Strength:

Area of Concern:

Play Skills

Does your child:

	Most of the time	Sometimes	Never
Seek out activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safely participate in activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prefer group activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prefer one-on-one activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prefer competitive activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play compatibly with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What else is important to you about your child's play skills?

Area of Strength:

Area of Concern:

Friends

Does your child have a best friend? Yes No If yes, for how long? _____

Does your child have: Lot of friends Few friends No friends

Is your child picked on/ bullied on by other children: Never Sometimes Frequently

Explain:

Does your child pick on /bully other children? Yes No

Explain:

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

What else is important to you about your child's friendships?

Area of Strength:

Area of Concern:

Recreation

Does your child participate in any activities on a regular basis? Yes No

Does your child have a favorite activity? Yes No

If yes, please explain:

Does your child have an interest in:

Sports Clubs Church Community Center Other

Please explain:

What else is important to you about your child's recreation?

Area of Strength:

Area of Concern:

Safety

Does your child:

- | | Yes | No |
|--|--------------------------|--------------------------|
| • Identify and avoid dangerous situations?
<i>If no, explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Engage in serious risk-taking behaviors?
<i>If yes, explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Follow safety rules (crossing street, etc.)?
<i>If no, explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Identify safety items (first aid kit, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Know how to contact emergency services? | <input type="checkbox"/> | <input type="checkbox"/> |

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

What else is important to you about your child's safety?

Area of Strength:

Area of Concern:

BEHAVIORAL FUNCTIONING

The information gathered in this section will be directly connected to the Individual Treatment Plan (ITP). The purpose is to gather specific information about your child's behavioral functioning. In areas that are a concern the supervisor should be able to specifically describe the following:

- o The behaviors that are challenging for your child and family
- o The circumstances when the behavior occurs
- o The circumstances when the behavior does not occur
- o The things your child is currently able to do to control the behavior
- o What your child needs to be able to do to control the behavior

Keeping in mind the child's developmental level and the family's cultural context, use the following to learn about the parent's perceptions of their child's self-awareness.

Attention

How many minutes can your child focus at a time on something interesting? _____ Minutes

How many minutes can your child focus at a time in something not interesting? _____ Minutes

How would you describe your child's level of distractibility? High Moderate Low

After being distracted, your child returns to a task: Easily Needs help Cannot refocus

What distracts your child?

Sounds Sights Touch People Other Specify: _____

How would you describe your child's ability to tolerate frustration? High Moderate Low

If Low, please describe how your child behaves when frustrated:

What else is important to you about your child's ability to pay attention?

Area of Strength:

Area of Concern:

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Behaviors

Would you describe your child as:

- | | Yes | No |
|----------------------------|--------------------------|--------------------------|
| • Impulsive | <input type="checkbox"/> | <input type="checkbox"/> |
| • Explosive | <input type="checkbox"/> | <input type="checkbox"/> |
| • Oppositional | <input type="checkbox"/> | <input type="checkbox"/> |
| • Anxious | <input type="checkbox"/> | <input type="checkbox"/> |
| • Inflexible with routines | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, please explain:

Would you describe your child as verbally aggressive? Yes No

If yes, is your child verbally aggressive toward:

- | | | |
|------------------|------------------------------|-----------------------------|
| • Family members | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Other children | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Adults | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Animals | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Does your child injure him/herself? Yes No

If yes, please describe how and how often:

Is your child physically violent? Yes No

If yes, is your child physically aggressive toward:

- | | | |
|------------------|------------------------------|-----------------------------|
| • Family members | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Other children | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Adults | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Animals | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Property | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, please describe how and how often your child is physically aggressive:

Does your child have inappropriate sexual impulses or activity? Yes No

If yes, please explain:

Does your child have:

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| • Repetitive patterns of behavior? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Unique motor mannerism? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, please explain:

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

Is there anything else you would like to share about your child's behavior?

Area of Strength:

Area of Concern

FUNCTIONAL LIFE SKILLS – ACTIVITIES OF DAILY LIVING

The information gathered in this section will be directly connected to the Individual Treatment Plan (ITP). The purpose is to gather specific information about your child's abilities to perform activities of daily living. In areas that are a concern the supervisor should be able to specifically describe the following:

- o The circumstances when the skill is performed
- o How your child currently performs the skill
- o The circumstances when the skill is not performed
- o What the child needs to maximize her/his capacity to perform the skill

Keeping in mind the child's developmental level and the family's cultural context, use the following to learn about the parent's perceptions of their child's ability.

Communication

How does your child communicate?

- Verbally Yes No Sometimes
- Sign Language Yes No Sometimes
- With the help of adaptive equipment Yes No Sometimes
- Other Yes No Sometimes

Explain:

Does your child:

- Make eye contact? Yes No Sometimes
- Respond to his/her name? Yes No Sometimes
- Communicate information about her/himself? Yes No Sometimes

Explain:

Does your child have a favorite learning style? (Please specify below) Yes No Sometimes

Visual Auditory Touch Verbal Combination

Explain:

Does your child follow directions? Yes No Sometimes

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

Explain:

How long does it take your child to process information?

What else is important to you about your child's communication?

Area of Strength:

Area of Concern:

Physical Ability

Please rate your child's ability in this area using the following key:

0 = Independent 1 = Minimal support 2 = Needs support in specific areas 3 = Regular supervision/support 4 = Dependent on others
--

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|-------------------------------|------------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| ▪ Walk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Perform gross motor skills? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Perform fine motor skills? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Use adaptive equipment? | Yes <input type="checkbox"/> | | No <input type="checkbox"/> | | |
- If yes, please describe:*

What else is important to you about your child's physical ability?

Area of Strength:

Area of Concern:

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Feeding Skills

Please rate your child's ability in this area using the following key:

<p>0 = Independent 1 = Minimal support 2 = Needs support in specific areas 3 = Regular supervision/support 4 = Dependent on others</p>

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ▪ Feed her/himself safely? | <input type="checkbox"/> |
| ▪ Use adaptive equipment? | <input type="checkbox"/> |

What else is important to you about your child's feeding skills?

Area of Strength:

Area of Concern:

Personal Hygiene

Please rate your child's ability in this area using the following key:

<p>0 = Independent 1 = Minimal support 2 = Needs support in specific areas 3 = Regular supervision/support 4 = Dependent on others</p>

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ▪ Use the toilet appropriately? | <input type="checkbox"/> |
| ▪ Wash his/her hands after using the toilet? | <input type="checkbox"/> |
| ▪ Brush his/her teeth? | <input type="checkbox"/> |
| ▪ Shower or bathe? | <input type="checkbox"/> |
| ▪ Wash her/his hair? | <input type="checkbox"/> |
| ▪ Brush/comb her/his hair? | <input type="checkbox"/> |
| ▪ Shave? | <input type="checkbox"/> |
| ▪ Perform the tasks associated with menstruation? | <input type="checkbox"/> |

What else is important to you about your child's personal hygiene?

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

Area of Strength:

Area of Concern:

Dressing

Please rate your child's ability in this area using the following key:

0 = Independent 1 = Minimal support 2 = Needs support in specific areas 3 = Regular supervision/support 4 = Dependent on others
--

Does your child:

	0	1	2	3	4
▪ Lace & Tie	<input type="checkbox"/>				
▪ Button	<input type="checkbox"/>				
▪ Snap	<input type="checkbox"/>				
▪ Buckle	<input type="checkbox"/>				
▪ Zip	<input type="checkbox"/>				
▪ Dress her/himself?	<input type="checkbox"/>				
▪ Undress her/himself?	<input type="checkbox"/>				
▪ Choose appropriate clothing for weather conditions?	<input type="checkbox"/>				

What else is important to you about your child's dressing skills?

Area of Strength:

Area of Concern:

Time Awareness

Developmentally appropriate? Yes No

Does your child:

▪ Understand before and after?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
▪ Understand yesterday, today and tomorrow?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
▪ Anticipate what comes next?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
▪ Know the time of day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
▪ Tell time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Child/Youth: _____ Agency: _____

State of Maine

**Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment**

- Follow a daily routine? Yes No

What else is important to you about your child's time awareness?

Area of Strength:

Area of Concern:

FUNCTIONAL LIFE SKILLS – INDEPENDENT LIVING

The information gathered in this section will be directly connected to the Individual Treatment Plan (ITP) for a **youth age 14 and older**. The purpose is to gather specific information about the child's skills for independent living. In areas that are a concern the supervisor should be able to specifically describe the following:

- o The circumstances when the skill is performed
- o How your child currently performs the skill
- o The circumstances when the skill is not performed
- o What the child needs to maximize her/his capacity to perform the skill

Keeping in mind the child's developmental level and the family's cultural context, use the following to learn about the parent's perceptions of their child's ability.

Medications

Does your child:

- Understand what the medication is for? Yes No
- Follow a medication schedule? Yes No
- Self-medicate? Yes No

Home Living Skills

Please rate your child's ability in this area using the following key:

0 = Independent
1 = Minimal support
2 = Needs support in specific areas
3 = Regular supervision/support
4 = Dependent on others

Does your child:

- Pick up after her/himself?

0	1	2	3	4
<input type="checkbox"/>				
- Make own bed?

0	1	2	3	4
<input type="checkbox"/>				

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

- Dust and vacuum?
- Wash dishes?
- Clean bathtub and toilet?

What else is important to you about your child's home living skills?

Area of Strength:

Area of Concern:

Laundry

Please rate your child's ability in this area using the following key:

- | |
|---|
| <p>0 = Independent
1 = Minimal support
2 = Needs support in specific areas
3 = Regular supervision/support
4 = Dependent on others</p> |
|---|

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Distinguish between clean and dirty? | <input type="checkbox"/> |
| • Operate a washing machine? | <input type="checkbox"/> |
| • Safely operate a clothes dryer? | <input type="checkbox"/> |
| • Fold and put away clothes? | <input type="checkbox"/> |

What else is important to you about your child's laundry skills?

Area of Strength:

Area of Concern:

Child/Youth: _____ Agency: _____

State of Maine
Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment

Food Preparation

Please rate your child's ability in this area using the following key:

0 = Independent
1 = Minimal support
2 = Needs support in specific areas
3 = Regular supervision/support
4 = Dependent on others

Does your child:

	0	1	2	3	4
• Identify basic foods?	<input type="checkbox"/>				
• Prepare simple uncooked meals?	<input type="checkbox"/>				
• Prepare simple cooked meals?	<input type="checkbox"/>				
• Store food properly?	<input type="checkbox"/>				
• Safely use a stove?	<input type="checkbox"/>				
• Safely use a microwave?	<input type="checkbox"/>				
• Set a table?	<input type="checkbox"/>				
• Make a grocery-shopping list?	<input type="checkbox"/>				
• Shop at the grocery store?	<input type="checkbox"/>				

What else is important to you about your child's food preparation skills?

Area of Strength:

Area of Concern:

Community Skills

Please rate your child's ability in this area using the following key:

0 = Independent
1 = Minimal support
2 = Needs support in specific areas
3 = Regular supervision/support
4 = Dependent on others

Does your child use:

	0	1	2	3	4
• Telephone?	<input type="checkbox"/>				
• Email?	<input type="checkbox"/>				
• Post office?	<input type="checkbox"/>				
• Public transportation?	<input type="checkbox"/>				

Child/Youth: _____ Agency: _____

State of Maine

**Department of Health and Human Services, Office of Child & Family Services
Section 24: Comprehensive Assessment**

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Make and keep appointments? | <input type="checkbox"/> |
| • Plan an activity with a friend? | <input type="checkbox"/> |
| • Order from a menu? | <input type="checkbox"/> |
| • Participate in exercise/sporting/other activities? | <input type="checkbox"/> |

Does your child:

- Understand the basic rights and responsibilities of living in a community? Yes No
- Recognize an emergency situation? Yes No
- Know how to get help? Yes No

What else is important to you about your child's community skills?

Area of Strength:

Area of Concern:

Money

Please rate your child's ability in this area using the following key:

- | |
|--|
| 0 = Independent
1 = Minimal support
2 = Needs support in specific areas
3 = Regular supervision/support
4 = Dependent on others |
|--|

Does your child:

- | | 0 | 1 | 2 | 3 | 4 |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Identify bills and coins? | <input type="checkbox"/> |
| • Make change? | <input type="checkbox"/> |
| • Make purchases? | <input type="checkbox"/> |
| • Save money? | <input type="checkbox"/> |
| • Make and follow a budget? | <input type="checkbox"/> |

Does your child:

- Understand the concept of money? Yes No
- Understand the concept of using a bank? Yes No
- Need a representative payee? Yes No
- Maintain a bank account? Yes No

Child/Youth: _____ Agency: _____

State of Maine

Department of Health and Human Services, Office of Child & Family Services

Section 24: Comprehensive Assessment

If yes, specify type:

Checking	<input type="checkbox"/>
Savings	<input type="checkbox"/>
Both	<input type="checkbox"/>

What else is important to you about your child's money skills?

Area of Strength:

Area of Concern: