**MaineCare Section 28,**
**Rehabilitative and Community Support Services**
**for Children with Cognitive Impairments and Functional Limitations**

# Comprehensive Assessment: A Guide To Conversation


State of Maine
Department of Health and Human Services
Office of Child and Family Services

MaineCare Section 28, Rehabilitative and Community Support Services for
Children with Cognitive Impairments and Functional Limitations
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## Introduction

This comprehensive assessment has been developed by the Department of Health and Human Services, Office of Child and Family Services, in cooperation with parents and providers. The purpose of this tool is to provide a standard format in which to hold a conversation between the parent and the provider. It is our hope that parents will be able to describe their child in a way that will help providers better identify the child's strengths and needs in order to provide more individualized treatment 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, such as relatives, friends, teachers, daycare provider, or others that may be applicable. Over time the provider's own observations will add to their understanding of the child's strengths and needs, and this information will assist the treatment team in developing an appropriate, individualized treatment plan.

## Table of Contents

## Signature Page

Parent/Guardian/Caregiver:

I talked with _____ from
Agency Person

_____ to help the agency learn about my child,
Agency

_____ 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 at any time.

_____ _____
Parent/Guardian/Caregiver Date

_____ _____
Child/Youth Date

**Provider Use Only:**

Date Provider Accepted Referral: _____

Comprehensive Assessment:

Guide to Conversation completed by: _____

Title: _____ Date: _____

## Identifying Information

**Child/Youth:** _____

**DOB:** _____ **Age:** _____ **Gender:** _____

**MaineCare #:** _____ **Social Security #:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Own Guardian:** ☐ Yes ☐ No

**Primary Diagnosis Name and Code:**

**DSM-IV-TR**

Axis I: _____ Date of Dx: _____

Axis II: _____ Date of Dx: _____

Axis III: _____ Date of Dx: _____

Axis IV: _____ Date of Dx: _____

Axis V: _____ Date of Dx: _____

IQ Score: _____ Name of Assessment: _____ Date: _____

**Diagnostic Classification System for Infants and Young Children (DC-0-3R)**

Axis I**:** _____ Date of Dx: _____

**Functional Assessment**

Name of Assessment: _____ Date: _____

Score: Composite: _____

Communication: _____

Social: _____

Strengths: _____

Interests: _____

Reason for Referral: _____

Presenting Problem(s): _____

## Emergency Contacts

**Emergency Contact When Parent is Unavailable:**

Name: _____ Relationship to child: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Child's Name: _____

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? _____

Whom does the worker call when there is an emergency involving the following?

Allergy: _____

Seizure: _____

Accident: _____

Other: _____

## Contact List

**Mother:**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Father:**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Guardian (if not parent):**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Other Parenting Figure (foster parent, kinship care etc.):**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Extended Family Member(s) or Natural Supports:**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Extended Family Member(s) or Natural Supports:**

Name: _____
Address: _____
Phone : _____ Phone: _____ Email: _____
Release completed: ☐ Yes Release expires: _____

**Siblings:**

| Name | Age | Live with Child: | Release Complete | Release Expires |
|---|---|---|---|---|
| | | ☐ Y ☐ N | ☐ Y ☐ N | |
| | | ☐ Y ☐ N | ☐ Y ☐ N | |
| | | ☐ Y ☐ N | ☐ Y ☐ N | |
| | | ☐ Y ☐ N | ☐ Y ☐ N | |

## Services

**Case Management Agency**: _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Primary Care Doctor**: _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Other Doctor**: _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Therapist:** ☐ Occupational ☐ Physical ☐ Speech and Language ☐ Mental Health ☐ Other:
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Therapist:** ☐ Occupational ☐ Physical ☐ Speech and Language ☐ Mental Health ☐ Other:
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**School** _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Child Care Provider:** _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

**Other Provider:** _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Release completed: ☐ Yes ☐ No Release expires: _____

## Medical

**Health**:

☐ No Concerns ☐ Allergies ☐ Seizures ☐Diabetes ☐ Heart Condition ☐Other:

**Hearing:** _____ ☐ No Concerns ☐ Concerns

**Vision**: _____ ☐ No Concerns ☐ Concerns

**Dental**: _____ ☐ No Concerns ☐ Concerns

**Medications:**

Name: _____ Purpose: _____ Dose: _____ Frequency**:** _____

Name: _____ Purpose: _____ Dose: _____ Frequency**:** _____

Name: _____ Purpose: _____ Dose: _____ Frequency**:** _____

Name: _____ Purpose: _____ Dose: _____ Frequency**:** _____

**Weight:**

Do you and your child's doctor have any concerns about your child's weight? ☐ Yes ☐ No

If yes, please explain:

**Eating Habits:**

Do you have any concerns about your child's eating habits? ☐ Yes ☐ No

If yes, please explain:

**Sleep:**

| | Yes | No |
|---|---|---|
| Has there been a recent change in the child's sleep pattern? | ☐ | ☐ |
| Does your child: | | |
| • Sleep through the night? | ☐ | ☐ |
| • Have nightmares? | ☐ | ☐ |
| • Take naps? | ☐ | ☐ |
| Do you have concerns about your child's sleep patterns? | ☐ | ☐ |

Explain:

**Physical Complaints:**

| Does your child have**:** | Yes | No |
|---|---|---|
| • Frequent headaches? | ☐ | ☐ |
| • Frequent stomach aches? | ☐ | ☐ |
| • Frequent muscle pain? | ☐ | ☐ |
| • Frequent itching? | ☐ | ☐ |
| • Other? | ☐ | ☐ |

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

Explain:

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

If yes, please explain:

## Child's Developmental History

Developmental History: ☐ Known ☐ Unknown

| Developmental Milestones: | Normal Limits | Delay | Unknown |
|---|---|---|---|
| Motor | ☐ | ☐ | ☐ |
| Verbal | ☐ | ☐ | ☐ |
| Cognitive | ☐ | ☐ | ☐ |
| Emotional | ☐ | ☐ | ☐ |
| Social | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ |

Other Information: _____

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

## Child Care

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

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

Are there barriers preventing your child from attending child care? ☐ Yes ☐ No

If yes, please explain:

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

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|
| | | | | | | |

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?

## Education

**School Program:**

Type of school program:

Head Start ☐ Preschool ☐ Public Pre-K ☐
Home School ☐ Public School ☐ Private School ☐
Other: ☐ _____

Is your child involved with Child Development Services? ☐ Yes ☐ No

Grade level: _____

Child's Schedule - Include Transportation Time

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|
| | | | | | | |

Does your child receive Special Education services? ☐ Yes ☐ No

- ☐ Mainstreamed class
- ☐ 1:1 in regular classroom
- ☐ Resource Room
- ☐ Self-contained classroom
- ☐ Other (please specify)

Describe any Special Education Services/Supports currently received:

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

## Social Functioning

**Consider the developmental ability of the child when responding**

**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) ☐ Other

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 | ☐ | ☐ |
| Co-operative | ☐ | ☐ |
| Patient | ☐ | ☐ |

If no to any of the above, please explain:

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

Area of Strengths:

Area of Concerns:

| **Self-Awareness:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child**:** | | | |
| Identify feelings (sad, glad, mad, hurt, and scared)? | | | |
| Notice the responses of others to his/her behavior? | | | |
| Notice the responses of others to his/her statements? | | | |
| Identify two or more things he/she is interested in? | | | |
| Identify one thing he/she would like to improve? | | | |
| Identify rewards for him/her? | | | |
| **Self-Awareness Total** | | | |
| What else is important to you about your child's self-awareness? | | | |

| **Empathy:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child: | | | |
| Use words or signs to identify others feelings? | | | |
| Respond to others feelings? | | | |
| Is your child flexible in interactions when relating to others? | | | |
| **Empathy Total** | | | |
| What else is important to you about your child's empathy? | | | |

| **Managing Emotions:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child: | | | |
| Use words or age appropriate expressions of feelings? | | | |
| Ask for help when experiencing strong feelings s/he can not manage? | | | |
| Self-soothe when hurt, angry, sad, frightened? | | | |
| Tell others how s/he feels about their behavior? | | | |
| Tolerate criticism? | | | |
| Problem-solve in challenging situations? | | | |
| Manage disagreement with compromise or negotiation? | | | |
| **Managing Emotions Total** | | | |
| What kinds of things soothe your child?<br><br>What else is important to you about your child's managing emotions? | | | |

| **Non-Verbal Relationship Skills:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child**:** | | | |
| Set personal physical boundaries? | | | |
| Respect personal physical boundaries? | | | |
| Use non-verbal communication? | | | |
| Respond to non-verbal communication? | | | |
| Use developmentally/culturally appropriate eye contact? | | | |
| Listen to others? | | | |
| Adjust behavior to fit into new situations? | | | |
| **Non-Verbal Relationship Skills Total** | | | |
| What else is important to you about your child's non-verbal relationship skills? | | | |

| **Social Interactions:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child**:** | | | |
| Start a conversation? | | | |
| Introduce appropriate topics in conversation? | | | |
| Give directions? | | | |
| Ask for help? | | | |
| End a conversation? | | | |
| Enter a group appropriately? | | | |
| Leave a group appropriately? | | | |
| **Social Interactions Total** | | | |
| What else is important to you about your child's social interactions skills? | | | |

| **Interpersonal:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child**:** | | | |
| Give compliments? | | | |
| Accept compliments? | | | |
| Share problem with a friend(s)? | | | |
| Give advice? | | | |
| Share objects, ideas, and information? | | | |
| Offer to help others? | | | |

| **Interpersonal:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| | | | |
| Admit mistakes? | | | |
| Make apologies? | | | |
| Show appropriate interactions with opposite sex? | | | |
| **Interpersonal Total** | | | |
| What else is important to you about your child's interpersonal skills? | | | |

| **Play Skills:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never* | Date | Date | Date |
| Does your child**:** | | | |
| Seek out activities? | | | |
| Safely participate in activities? | | | |
| Play compatibly with others? | | | |
| **Play Skills Total** | | | |
| What else is important to you about your child's play skills? | | | |

| | Date | Date | Date |
|---|---|---|---|
| **Social Functioning Total** | | | |

| **Friends:** | | | |
|---|---|---|---|
| *Rating Scale Varies:* | Date | Date | Date |
| | | | |
| Does your child have *1-Lots of friends; 2-Few friends; 3- No friends* | | | |
| Does your child have a best friend? *1-Yes; 2-No* | | | |
| Is your child picked on/bullied by other children? *1-Never; 2-Sometimes; 3-Frequently* | | | |
| Does your child pick on/bully other children? *1- Never, 2- Sometimes, 3-Frequently* | | | |
| What else is important to you about your child's friendships? | | | |

| **Leisure Time:** | | | |
|---|---|---|---|
| *Rating Scale: 1 - Yes; 2 - No* | Date | Date | Date |
| Does your child participate in any activity on a regular basis? | | | |
| Does your child have a favorite activity?<br>If yes, describe: | | | |
| Does your child have an interest in Sports ☐, Clubs ☐, Church, ☐ Community Center ☐ Other<br>If yes, describe: | | | |
| What else is important to you about your child's leisure time? | | | |

**Social Functioning Summary**

Areas of Strength:

Areas of Concern:

## Behavioral Functioning

**Consider the developmental ability of the child when responding.**

| **Safety:** | | | |
|---|---|---|---|
| *Rating Scale:*<br>*1 – Always; 2 – Most of the time; 3– Sometimes; 4 – Rarely; 5 – Never* | Date | Date | Date |
| Does your child: | | | |
| Identify dangerous situations? | | | |
| Avoid dangerous situations? | | | |
| If no, explain: | | | |
| Avoid serious risk-taking behaviors? | | | |
| If no, explain: | | | |
| Follow safety rules (crossing street, etc.)? | | | |
| If no, explain: | | | |
| Identify safety items (first aid kit, etc.)? | | | |
| Know how to contact emergency services? | | | |
| **Safety Total** | | | |
| What else is important to you about your child's safety? | | | |

| **Attention:** | | | | |
|---|---|---|---|---|
| How many minutes can your child focus at a time on something interesting? | ☐ < 5 | ☐ 10-15 | ☐ 30 | ☐ Other |
| How many minutes can your child focus at a time in something not interesting? | ☐ < 5 | ☐ 10-15 | ☐ 30 | ☐ Other |
| How would you describe your child's level of distractibility? | ☐ 1 Low | ☐ 2 Moderate | ☐ 3 High | |
| After being distracted, your child returns to a task | ☐ 1 Easily | ☐ 2 Needs help | ☐ 3 Cannot refocus | |
| What distracts your child?<br>☐ Sounds ☐ Sights ☐ Touch ☐People ☐ Other ☐ Specify: | | | | |
| How would you describe your child's ability to tolerate frustration? ☐ 1- High ☐ 2- Moderate ☐ 3-Low | | | | |
| If low, describe how your child behaves when frustrated: | | | | |
| What else is important to you about your child's ability to pay attention? | | | | |

| **Behaviors:** | | | |
|---|---|---|---|
| *Rating Scale:*<br>*1 – Never; 2- Rarely; 3 – Sometimes; 4 – Most of the time; 5 – Always* | Date | Date | Date |
| Would you describe your child as**:** | | | |
| • Impulsive | | | |
| • Explosive | | | |
| • Oppositional | | | |
| • Anxious | | | |
| • Inflexible with routines | | | |
| **Behavior Total** | | | |
| Describe how and how often: | | | |

| **Verbal Aggression:** | | | |
|---|---|---|---|
| *Rating Scale:*<br>*1 – Never; 2- Rarely; 3 – Sometimes; 4 – Most of the time; 5 – Always* | Date | Date | Date |
| If yes, is your child verbally aggressive toward**:** | | | |
| • Family members | | | |
| • Other children | | | |
| • Adults | | | |
| • Animals | | | |
| • Property | | | |
| **Verbal Aggression Total** | | | |

Does your child injure him/herself? ☐ Yes ☐ No
If yes, describe how and how often:

| **Physical Aggression:** | | | |
|---|---|---|---|
| *Rating Scale:*<br>*1 – Never; 2- Rarely; 3 – Sometimes; 4 – Most of the time; 5 – Always* | Date | Date | Date |
| If yes, is your child physically violent toward: | | | |
| • Family members | | | |
| • Other children | | | |
| • Adults | | | |
| • Animals | | | |
| • Property | | | |
| **Physical Aggression Total** | | | |
| If your child is physically aggressive please describe how and how often: | | | |

| | Date | Date | Date |
|---|---|---|---|
| **Behavior Totals** | | | |

Does your child have inappropriate sexual impulses or activity? ☐ Yes ☐ No
If yes, explain:

Does your child use repetitive patterns of behavior or unique motor mannerisms? ☐ Yes ☐ No
If yes, explain.

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

**Behavioral Functioning Summary**

Areas of Strength:

Areas of Concern

## Functional Life Skills- Activities of Daily Living

**Consider the developmental ability of the child when responding.**

| **Communication:** | | | |
|---|---|---|---|
| *Check all that apply* | Date | Date | Date |
| How does your child communicate? | | | |
| • Verbally | ☐ | ☐ | ☐ |
| • Sign Language | ☐ | ☐ | ☐ |
| • With the help of adaptive equipment | ☐ | ☐ | ☐ |
| • Other | ☐ | ☐ | ☐ |
| • Explain: | | | |
| *Rating Scale:*<br>*1 – Always; 2 – Most of the time; 3 – Sometimes; 4 – Rarely; 5 – Never* | Date | Date | Date |
| Does your child: | | | |
| • Make eye contact? | | | |
| • Respond to his/her name? | | | |
| • Follow directions? | | | |
| • Communicate information about her/himself? | | | |
| **Communication Total** | | | |

Does your child have a preferred learning style?
☐ Visual ☐ Auditory ☐ Touch ☐ Verbal ☐ Combination

How long does it take your child to process information?

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

| **Physical Ability:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| Does your child: | | | |
| • Walk? | | | |
| • Perform gross motor skills? | | | |
| • Perform fine motor skills? | | | |
| • Use adaptive equipment? | | | |
| **Physical Total** | | | |

| **Feeding Skills:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| Does your child: | | | |
| • Feed her/himself safely? | | | |
| • Use adaptive equipment? | | | |
| • Perform fine motor skills? | | | |
| **Feeding Skills Total** | | | |

| **Personal Hygiene:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| Does your child**:** | | | |
| • Use the toilet appropriately? | | | |
| • Wash his/her hands after using the toilet? | | | |
| • Brush his/her teeth? | | | |
| • Shower or bathe? | | | |
| • Wash her/his hair? | | | |
| • Brush/comb her/his hair? | | | |
| • Shave? | | | |
| • Perform the tasks associated with menstruation? | | | |
| **Personal Hygiene Total** | | | |

| **Dressing:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others*<br>Does your child: | Date | Date | Date |
| • Lace and tie? | | | |
| • Button? | | | |
| • Snap? | | | |
| • Buckle? | | | |
| • Zip? | | | |
| • Dress him/herself? | | | |
| • Undress her/himself? | | | |
| **Dressing Total** | | | |

| **Time Awareness:** | | | |
|---|---|---|---|
| *Rating Scale:*<br>*1 – Always; 2 – Most of the time; 3 – Sometimes; 4 – Rarely; 5 – Never* | Date | Date | Date |
| Does Your Child: | | | |
| • Understand before and after? | | | |
| • Understand yesterday, today, and tomorrow? | | | |
| • Anticipate what comes next? | | | |
| • Know the time of day? | | | |
| • Tell time? | | | |
| • Follow a daily routine? | | | |
| **Time Awareness Total** | | | |
| | | | |
| **Functional Life Skills - Activities of Daily Living Total** | | | |
| What else is important to you about your child's functional life skills? | | | |

| **Functional Life Skills – Activities of Daily Living Summary** |
|---|
| Areas of Strength: |
| Areas of Concern: |

## Functional Life Skills – Independent Living For Youth Age 14 and Older

**Consider the developmental ability of the child when responding.**

| **Medications:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Yes; 2- No* | Date | Date | Date |
| Does your child | | | |
| • Understand what the medication is for? | | | |
| • Follow a medication schedule? | | | |
| • Self-medicate? | | | |
| **Medication Total** | | | |

| **Home Living Skills:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| Is your child able to: | | | |
| • Pick up after her/himself? | | | |
| • Make own bed? | | | |
| • Dust and vacuum? | | | |
| • Wash dishes? | | | |
| • Clean bathtub and toilet? | | | |
| • Distinguish between clean and dirty? | | | |
| • Operate a washing machine? | | | |
| • Safely operate a clothes dryer? | | | |
| • Fold and put away clothes? | | | |
| **Home Living Skills Total** | | | |
| What else is important to you about your child's Home Living skills? | | | |

| **Food Preparation:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| Is your child able to: | | | |
| • Identify basic foods? | | | |
| • Prepare simple uncooked meals? | | | |
| • Prepare simple cooked meals? | | | |
| • Store food properly? | | | |
| • Safely use a stove? | | | |
| • Safely use a microwave? | | | |
| • Set a table? | | | |
| • Make a grocery-shopping list? | | | |
| • Shop at the grocery store? | | | |
| **Food Preparation Total** | | | |
| What else is important to you about your child's food preparation skills? | | | |

| **Community Skills:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| **Is your child able to :** | | | |
| • Use a telephone? | | | |
| • Use Email? | | | |
| • Use the post office? | | | |
| • Use public transportation? | | | |
| • Plan an activity with a friend? | | | |
| • Order from a menu? | | | |
| • Understand the basic rights and responsibilities of living in a community? | | | |
| • Recognize an emergency situation? | | | |
| • Know how to get help? | | | |
| **Community Skills Total** | | | |
| What else is important to you about your child's community skills? | | | |

| **Money:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| **Is your child able to:** | | | |
| • Identify bills and coins? | | | |
| • Make change? | | | |
| • Make purchases? | | | |
| • Use a Swipe card? | | | |
| • Save money? | | | |

| **Money:** | | | |
|---|---|---|---|
| *Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others* | Date | Date | Date |
| • Make and follow a budget? | | | |
| • Understand the concept of money? | | | |
| • Understand the concept of using a bank? | | | |
| • Maintain a bank account? | | | |
| If yes, specify type:<br>Checking ☐<br>Savings ☐<br>Both ☐ | | | |
| **Money Total** | | | |

Does your child need a representative payee? ☐Yes; ☐No

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

**Functional Life Skills – Independent Living**

Areas of Strength:

_____

Areas of Concern:

_____

## Transitional 18 – 20 Year Olds

**Guardianship:**

Is the youth his/her own guardian? ☐ Yes ☐ No

If no, was guardianship assigned by the probate court? ☐ Yes Date: ☐ No

**Guardian:**

Name: _____

Address: _____

Phone: _____

What is the plan for this individual at age 21?

How will this ITP help prepare the youth for the transition?