CONSUMER FORM

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| **CONSUMER INFORMATION** |
| Consumer’s Name\* (full legal first, mi, last): |  | DOB\*: |  |
| Parents or Guardians\*: |  | Relationship to Child\*: |  |
| Primary Address (street, city)\*: |  | State and Zip\*: |  |
| Mailing Address (street, city): |  | State and Zip: |  |
| Gender\*: |  | Primary Language\*: |  | Ethnicity/Tribe\*: |  |
| Phone\*: |  | Email: |  | SSN\*:  |  |
| Medicaid Member # or Insurance Provider\*:  |  |
| Staff taking Referral: |  | Referral Date: |  |
| **REFERRAL SOURCE INFORMATION** |
| Name of referral source\*: |  |
| Agency/Organization/Other\*: |  | E-mail: |  |
| Parent notified of referral\*: | [ ]  Yes [ ]  No  |
| Phone number of source\*: |  | Fax #: |  |
| Additional Information/ Reason for Referral\*: |  |

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|  **ADMIN USE ONLY**  |
| Date of Initial Contact: |  | Program: |  |
| Medcompass CSR Completed:  | [ ]  Yes [ ]  No  | Date Entered:  |  |
| **ASSESSMENT / PERCENT OF DELAYS** |
| Date of Assessment: | Enter date | Type of Assessment:  | Assessment |
| Cognitive | Physical | Communication | Adaptive | Social-Emotional |
| % Delay | % Delay | % Delay | % Delay | % Delay |
| Speech Therapy Referral Recommended | [ ]  Yes [ ]  No  | Consent [ ]  | Referral Sent [ ]  | Provider: enter text  |
| Occupational Therapy Referral Recommended | [ ]  Yes [ ]  No  | Consent [ ]  | Referral Sent [ ]  | Provider: enter text  |
| Physical Therapy Referral Recommended | [ ]  Yes [ ]  No  | Consent [ ]  | Referral Sent [ ]  | Provider: enter text  |
|  **INTAKE & ELIGIBILITY REVIEW PANEL (ERP)** |
| Date of ERP: | Enter date | MSDB Services: | [ ]  Vision [ ]  Hearing [ ]  None |
| Intake Date: | Enter date | Age of Child: |  enter text  | Diagnosis code: | enter |
| Eligible? | [ ]  Yes [ ]  No  | Eligibility Date: |  enter text  | Type: | Type |
| Background |  enter text  |
| FSS Assigned: |  enter text  |
| ERP Attendees: | Nicole Hofmeister, EISM; Macey Curry, SSS; Julia Robinson, SSS; Amy Simpson, SSS, Lori Fisher LeDeau, SSS Rosemary Alferez, FSC; Amy Ferguson, FSC; Kristen Ryan, FSC; Faith Ford, PT |

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| **EXIT SUMMARY FORM** |
| Program exiting from: | Choose an item. | Date of Exit: | Enter date |
| Agency/Organization/Other: |  | Reason for Exit: | Choose an item. |
| Family Support Specialist: | FSS Assigned | Exit Code: | Attempts to contact unsuccessful |
| **MOST RECENT ASSESSMENT** |
| Date of Assessment: | Enter date | Type of Assessment: | Assessment |
| Cognitive | Physical | Communication | Adaptive | Social-Emotional |
| % Delay | % Delay | % Delay | % Delay | % Delay |
| Are there still concerns about the consumer’s developmental delays? | [ ]  Yes [ ]  No  |
| If yes, describe:  |  enter text  |
| **PART C CONSUMERS ONLY** |
| **TRANSITION**  |
| Transition Plan Due Date:  | Enter date | Date Transition Plan was added to IFSP: | Enter date |
| Was a transition meeting with Part B/SPED services completed? | [ ]  Yes [ ]  No  | Date of meeting: | Enter date |
| If a transition meeting was not held, explain why: |  enter text  |
| Was the LEA notification sent? | [ ]  Yes [x]  No  | Date of notification: | Enter date |
| Name of district or cooperative: |  enter text  |
| Was a referral to Part B/SPED services completed? | [ ]  Yes [ ]  No  | Date of Referral: | Enter date |
| If Part B/SPED service referral was not sent, explain why: |  enter text  |
| **CHILD OUTCOME SUMMARY (COS)** |
| Was a COS completed? | [x]  Yes [ ]  No  | Date of Baseline COS: | Enter date | Date of Exit COS: | Enter date |
| If not, why: |  enter text  |
| Baseline COS ratings: | Outcome #1: | Rating | Outcome #2: | Rating | Outcome #3: | Rating |
| Exit COS ratings: | Outcome #1: | Rating | Outcome #2: | Rating | Outcome #3: | Rating |
| Exit COS New Skills:  | Outcome #1: | [ ]  Yes [ ]  No  | Outcome #2: | [ ]  Yes [ ]  No  | Outcome #3: | [ ]  Yes [ ]  No  |
| **SSS USE ONLY**  |
| **CONSUMER PROGRAM EXIT TASKS** |
| [ ]  | IFSP & Care Plan Completed in Medcompass | Date: | Enter Date | Initials: | enter |
| [ ]  | Exit COS completed (if applicable) with fidelity checklist | Date: | Enter Date | Initials: | enter  |
| [ ]  | Ensure end date was added to consumer database history (PA) | Date: | Enter Date | Initials: | enter |
| [ ]  | Upload exit summary to ‘Documents’ in Medcompass | Date: | Enter Date | Initials: | enter  |
| [ ]  | Ensure CSR & Program card are completed in Medcompass (unexpected Part C & FES exits) | Date: | Enter Date | Initials: | enter  |
| [ ]  | Email to FSS | Date:  | Enter Date | Initials: | enter  |
| COMMENTS: |  enter text  |

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| Staff Signature: |  | Date: |  |
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| Supervisor Signature: |  | Date: |  |
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| Date Backfilled: |  | Date: |  |