Text

Description automatically generatedCONSUMER 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  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? | | | | 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: |  |
|  |  | | |  |  |
| Supervisor Signature: | | |  | Date: |  |
|  | | |  |  |  |
| Date Backfilled: | |  | | Date: |  |