Barrier Screening Tool

wisconsin department of children + families

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Department of Children and Families
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WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES

The Functional Screen

Note to Interviewer: The W-2 Barrier Screening Tool Agreement must be reviewed with the participant and signed before you begin.

Interviewer narrative: *First, I have questions about your ability to get around.*

A. Mobility	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
A1. *Are you experiencing any problems walking fast or walking long distances?*				
A2. *Do you need help from either a person or a device (for example a cane or a walker) to walk and/or drive a car?*				
A3. *Do you need help to get around in the community?*				
If answer to A3. is "All of the time" or "Most of the time," ask for explanation: ***"****Please explain what type of help do you need and why****"***	_____ _____			

Interviewer: If the response to any of the above questions is "All of the time," or "Most of the time," follow up by asking: "Will this condition cause any problems with your participation in work or work training? If yes, "Please tell me how." Write in response below:

_____
_____
_____
_____
_____
_____
_____
_____

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer narrative: *This next set of questions asks about your physical abilities.*

B. **PHYSICAL DEMANDS**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
B1. *Do you have problems standing or sitting for long periods of time?*				
B2. *Do you have problems bending, stooping or squatting?*				
B3. *Do you have any difficulties lifting?*				
B4. *Do you have difficulties climbing or keeping your balance?*				

Interviewer: If the response to any of the above questions is "All of the time," or "Most of the time," follow up by asking: "*Will this condition cause any problems with your participation in work or work training?* If yes, *"Please tell me how."* Write in response below:

_____
_____
_____
_____

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer Narrative: *The next three questions have to do with your sensitivity to smells, noise and temperature.*

C. **ENVIRONMENTAL CONDITIONS**	**Yes**	**No**
C1. *Are you allergic to any dust, fumes or smells?*		

Interviewer: If the response is "Yes," follow up by asking: "*Will this condition cause any problems with your participation in work or work training?* If yes, *"Please tell me how."* Write in response below:

_____
_____
_____

C. **ENVIRONMENTAL CONDITIONS**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
C2. *Are you having trouble with noise or vibrations?*				

Interviewer: If answer is "All of the time," or "Most of the time," ask for more information*; "Give me examples of the ways in which you have trouble with noise and vibrations":*

_____
_____
_____
_____

C. **ENVIRONMENTAL CONDITIONS**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
C3. *Do you have difficulties with extreme temperatures?*				

Interviewer: If answer is "All of the time," or "Most of the time," ask for more information**;** *"Give me examples of the ways in which you have trouble with extreme temperatures."*

_____
_____
_____
_____
_____
_____

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer Narrative: *Next, I am going to ask you questions about being able to function independently, without help.*

D. **SELF CARE**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
D1. *Do you have problems cooking, shopping, or performing other household chores by yourself?*				
D2. *Do you need assistance handling money?*				
D3. *Do you forget or need reminders to pay bills on time or keep track of appointments?*				
D4. *Do you have difficulty remembering what you have just been told, or what you heard recently?*				

Referral Information: Refer for Screen 2 if answer to any of the questions is “All of the time” or “Most of the time”.

Interviewer Narrative: *We are more than halfway through the screen. The next set of questions is about how you interact with people.*

E. **COMMUNICATIONS**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
E1. *Do people have trouble understanding what you say?*				
E2. *Do you have trouble explaining to others what you want or need?*				
E3. *Do you have difficulty understanding or remembering what you read?*				
E4. *Do you have difficulty expressing yourself in writing?*				
E5. *Do you have trouble concentrating on work?*				

Referral Information: Refer for Screen 2 if answer to any of the questions is "All of the time" or "Most of the time."

F. **SOCIAL SKILLS**	**All of the time**	**Most of the time**	**Some of the time**	**None of the time**
F1. *Do you feel uncomfortable around other people, in crowds or in unfamiliar places?*				
F2. *Do you get angry or frustrated easily? Or, has anyone else ever told you that you get angry or frustrated easily?*				
F3. *Do you have trouble taking directions from a supervisor?*				
F4. *Do you have trouble asking for help when you are having a difficult time with tasks?*				

Referral Information: Refer for Screen 2 if answer to any of the questions is "All of the time" or "Most of the time."

Interviewer Narrative: *We are almost done with the screening. The remaining questions require a "Yes" or "No" answer, and we should be able to get through all of them quickly.*

G. **WORK LIMITATIONS**	**Yes**	**No**
G1. *Do you have any medical problems (e.g., diabetes, epilepsy /seizures, heart disease, TB)*		
If yes, *"Please tell me what medical problems you are having:"*	_____ _____ _____ _____ _____	

Interviewer: If medical condition is identified, follow up by asking:
"Will this condition cause any problems with your participation in work or work activities?" If yes, "*Please tell me how."* Write in response below:

_____
_____
_____

Referral Information for G1: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work, or to take part in a job training program.

G. **WORK LIMITATIONS**	**Yes**	**No**
G2. *Are you currently having problems with:*		
a. *Alcohol or drug use* **Referral Information for G2a:** Refer to AODA service provider for assessment if answer is "Yes."		
b. *Anxiety* **Referral Information for G2b:** Refer for Screen 2 if answer is "Yes."		
c. *Depression* **Referral Information for G2c:** Refer for Screen 2 if answer is "Yes."		
G3. *When you were in school did you ever find yourself falling behind and needing extra help with learning? Or, Were you ever in special education classes?* **Referral Information for G3:** Refer for Screen 2 if answer to either question is "Yes."		

Interviewer Comments: *Is there any thing else that I have not covered that you think would be important for me to know?*

_____
_____
_____
_____
_____
_____
_____
_____

Interviewer Narrative: *Thank you for taking the time to do this screen.*

Domestic Abuse Screen
Interviewer Version

Interviewer Narrative: *Because so many people are harmed by domestic abuse and sexual assault, we ask the following questions of everyone who comes to us for assistance. These questions will help us find out how best to serve you and connect you with services that you need. The information you share about yourself through this screen will be kept confidential.*

If you're uncomfortable with answering any of the questions about domestic abuse or sexual assault, let me know and we'll move on to the next question or you can ask to stop the interview. You will not be penalized in any way for the way you answer the questions.

If you prefer, I can find a quiet spot where you can sit down and answer the questions on your own.

Note to interviewer: Some of the questions below refer to a relationship between the participant and a "partner". Please explain the following to the participant. For purposes of the screen "partner" can include any of the following: a spouse or former spouse; an adult with whom the individual has or had a dating relationship, an adult with whom the person has a child in common, an adult or minor family member, or an adult or minor with whom the person resides or formerly resided. This is to acknowledge the broad circumstances in which domestic abuse can occur.

#	Question	YES	NO
1	Is someone hurting you, your children, your other family or friends, or your pet(s)?		
2	Have you ever been in a relationship in which your partner has harmed you either physically or sexually? (examples: punching, grabbing, pushing, choking, restraining)?		
3	Has your partner ever refused to let you have money, made you ask for money, or took money from you against your will?		
4	Have you ever received services or lived in a shelter for victims of domestic abuse or sexual assault?		
5	Is someone emotionally or verbally abusing you or your children?		
6	Does your current or former partner call, harass or stalk you at work or training classes?		
7	Does your partner keep you awake all night so you will miss work or classes?		
8	Is your partner doing anything to make it difficult for you to work or do other activities in your daily life?		
9	Are you or any of your children feeling overwhelmed with the trauma of a rape or sexual assault?		
10	Are you involved with the court system due to domestic violence or sexual assault?		

INTERVIEWER: *Thank you for your patience and cooperation*.

SCORING/REFERRAL: One or more “yes” answers (in either current or past relationship) may indicate the need to refer the participant to local domestic abuse and/or sexual assault services for safety planning, counseling or housing needs. A referral to a local domestic abuse and/or sexual assault agency may be made as a result of how the participant responded to the screen ***or*** as a result of your informal observations and discussions with the participant. Follow through on the referral is not mandatory for the participant. S/he will choose whether or not to access the services depending on her/his situation.

Interviewer Notes: Regardless of how the participant answered the screen, please share with her/him pamphlets and brochures offering information on the issue of domestic abuse and/or sexual assault and about the local agencies that offer domestic abuse and/or sexual assault services. The participant may choose not to take the pamphlets and brochures with them, as doing so may endanger them; therefore, this decision should be respected.

Good Cause Claim: At this time, depending on the screen outcome, it may be appropriate to review the Good Cause Claim form which explains how to claim good cause for not cooperating with child support.

Domestic Abuse Screen
Self-Administered Version

Introduction

Because so many people are harmed by domestic abuse and sexual assault we ask the following questions of everyone who comes to us for assistance. These questions will help us find out how best to serve you and connect you with services that you need. The information you share about yourself through this screen will be kept confidential.

If you're uncomfortable with answering any of the questions about domestic abuse or sexual assault, you may move on to the next question or choose not to complete the questions. You will not be penalized in any way for the way you answer the questions.

Some of the questions below refer to a relationship with a "partner." For purposes of this screen "partner" can include any of the following: a spouse or former spouse; an adult with whom you have or had a dating relationship, an adult with whom you have a child in common, an adult or minor family member, or an adult or minor with whom you reside or formerly resided. This is to acknowledge the broad circumstances in which domestic abuse can occur.

#	Question	YES	NO
1	Is someone hurting you, your children, your other family or friends, or your pet(s)?		
2	Have you ever been in a relationship in which your partner has harmed you either physically or sexually? (examples: punching, grabbing, pushing, choking, restraining)?		
3	Has your partner ever refused to let you have money, made you ask for money, or took money from you against your will?		
4	Have you ever received services or lived in a shelter for victims of domestic abuse or sexual assault?		
5	Is someone emotionally or verbally abusing you or your children?		
6	Does your current or former partner call, harass or stalk you at work or training classes?		
7	Does your partner keep you awake all night so you will miss work or classes?		
8	Is your partner doing anything to make it difficult for you to work or do other activities in your daily life?		
9	Are you or any of your children feeling overwhelmed with the trauma of a rape or sexual assault?		
10	Are you involved with the court system due to domestic violence or sexual assault?		

Thank you for your patience and cooperation. Please return this to your FEP or case worker.

If you have any questions about this or would like any information about domestic abuse or domestic abuse providers, please ask your FEP or case manager.

WISCONSIN DEPARTMENT OF WORKFORCE DEVELOPMENT

Screen 2

Note to Interviewer: Screen 2 is only required when the Functional Screen indicates it is necessary.

Interviewer Narrative*: First, I want to ask you some questions about school and how you learn things.*

1. *Have you had any problems learning in grades six through eight?*	Yes	No
2. *Is it hard for you to work from a test book to an answer sheet?*	Yes	No
3. *Do you have trouble working with numbers in a column?*	Yes	No
4. *Do you have trouble judging distances?*	Yes	No
5. *Does anyone in your family have learning problems?*	Yes	No

A. Number of "yes" responses = _____

6. *Have you had any problems learning in grades one through five?*	Yes	No
7. *Do you have trouble mixing up math signs (=/x)?*	Yes	No

B. Number of "yes" responses multiplied by 2 = _____

8. *Do you have trouble filling out forms?*	Yes	No
9. *Do you have trouble memorizing numbers?*	Yes	No
10. *Do you have trouble remembering how to spell words you know?*	Yes	No

C. Number of "yes" responses multiplied by 3 = _____

11. *Do you have trouble taking notes?*	Yes	No
12. *Do you have trouble adding and subtracting small numbers in your head?*	Yes	No
13. *Were you ever in a special program or given extra help in school?*	Yes	No

D. Number of "yes" responses multiplied by 4 = _____

Total (A + B + C + D) = _____

Referral Information: If total is more than 12 refer to a psychologist, or DVR or private vocational rehabilitation agency.

Interviewer Narrative*: Now, I'd like to ask you a few questions about how you are dealing with things that may be bothering you.*

14. *Do you have trouble remembering details from your past?*	Yes	No
15. *Do you feel alone or isolated from people in your life?*	Yes	No
16. *Do you have trouble falling asleep or staying asleep?*	Yes	No
17. *Are you jumpy?*	Yes	No
18. *Do dreams or past memories cause you problems at work or in daily life?*	Yes	No
19. *Have you ever lost your appetite for two or more weeks? Or, have you ever lost or gained as much as two pounds a week for several weeks without trying?*	Yes	No
20. *During the past month have you felt afraid for no reason?*	Yes	No

Referral Information: Any two "yes" responses on questions 14-20, refer to a psychologist or DVR or private vocational rehabilitation agency.

Interviewer Narrative: *Now, I would like you to look at this piece of paper***.**

Note to Interviewer: Please give response sheet to participant.

Interviewer Narrative: *Pick the answer for each question that is closest to how often you think the situation has happened to you***.**

Note to Interviewer: Please circle the appropriate response for each of the questions.

	All of the time	Most of the time	A good bit of the time	Some of the time	Almost none of the time	None of the time
21. *How much of the time during the last month have you been a very nervous person?*	1	2	3	4	5	6
22. *How much of the time during the last month have you felt calm?*	6	5	4	3	2	1
23. *How much of the time during the last months have you felt down hearted and blue?*	1	2	3	4	5	6
24. *How much of the time during the last month have you been a happy person?*	6	5	4	3	2	1
25. *How much of the time during the last month have you felt so down in the dumps that nothing could cheer you up?*	1	2	3	4	5	6

Referral Information: **1.** Add up each of the numbers circled

Question 21 = ____
Question 22 = ____
Question 23 = ____
Question 24 = ____
Question 25 = ____

Total = _____

2. Divide up the total score by the number of questions answered (usually it would be 5).

Average score = ___

3. If the average score is less than 2.9, refer to a psychologist, or DVR, or private rehabilitation agency.

Interviewer Narrative: I would like to take a few more minutes and ask you some questions about any head injury you may have had.

26. *Have you ever had a significant blow or injury to your head?* Yes No

Note to Interviewer: If answer is "no," proceed to the next set of questions beginning with question 29.

If answer is "yes," proceed to question 27 below.

27. *Did you ever pass out for 15 minutes after a blow or injury to your head (for example after an accident or a fall)?* Yes No

Note to Interviewer*:* If answer is "no," proceed to the next set of questions beginning with question 29.

If "yes," proceed to question 28 below.

28. *After the blow and you passed out, did you experience any significant changes in:*

a. *Memory* Yes No
b. *Mood* Yes No
c. *Relationships* Yes No
d. *Ability to carry on as usual on a daily* b*asis* Yes No

Referral Information: If response to question 28 is "yes," refer to a psychologist, or DVR or private vocational rehabilitation agency**.**

Interviewer Narrative*:* *Finally, I'd like to ask you a few questions about your drug and alcohol use.*

29. *During the past year, has a friend or family member ever told you that they were worried about you or your behavior?*	Yes	No
30. *During the past year, has a friend or family member ever told you that they were worried about your drinking or drug use and suggested that you cut down?*	Yes	No
31*. Do you sometimes feel the need to cut down on your drinking or drug use?*	Yes	No
32. *Do you sometimes take a drink, use a drug, or get high in the morning when you first get up?*	Yes	No
33. *During the past year, has a friend or family member ever told you about things you said or did while you were drinking or using drugs that you could not remember?*	Yes	No
34. *During the past year, have you ever felt guilty or ashamed after drinking or using drugs?*	Yes	No
35. *During the past year, have you ever failed to do what was expected of you because of drinking or using drugs?*	Yes	No
36. *During the past year, have you ever lost friends, a girlfriend, boyfriend, spouse, or the custody of a child because of your drinking or drug use?*	Yes	No

Referral Information: One "yes" response to questions 30-36, refer to an AODA service provider.

Interviewer Narrative: *Thank you for your answers and your patience.*

Note to Interviewer: Please give this list to participant while you ask the questions.

Scoring Sheet for Screen 2
Questions 21 – 25

All of the time

Most of the time

A good bit of the time

Some of the time

Almost none of the time

None of the time

Section I Family Needs

Interviewer Narrative: *The following questions have to do with any family members in your household that may have special needs due to a disability or medical condition . This information will help me determine if special consideration must be given when you are assigned to work, training or other activities.*

Note to Interviewer: For any YES responses, the Summary should include name, age and relationship of family member and an explanation of the problem or special need described by the participant.

Do you have a family member in your household with special needs that make it difficult for you to work?
[ ] YES [ ] NO

Summary:
_____
_____
_____
_____

Do you have a family member in your household with medical problems?
[ ] YES [ ] NO

Summary:
_____
_____
_____

Do you have a family member in your house hold who is frequently suspended from school or work (or who gets in other trouble) due to behavioral problems?
[ ] YES [ ] NO

Summery:
_____
_____
_____

Do you have a child that misses school frequently?
[ ] YES [ ] NO

Summary:
_____
_____
_____

Do you have a child who is involved with child welfare services?
[ ] YES [ ] NO

Summary:
_____
_____
_____

Section I – Family Needs Summary:
_____
_____
_____
_____

Section II – Child With Special Needs

Child Part A. Background

1. *Do you have any concerns about your child's health or development?*
   [ ] YES [ ] NO

   If yes, what are these concerns?

   _____
   _____
   _____

2. *Please tell me if your child receives services from any of the following programs:*

   Interviewer: If response is YES for any of these programs, follow-up by asking: *Please tell me the contact name, phone number and why your child is seen by this program.*

   [ ] Birth-to-Three — Contact Name: / Contact Phone:

   Comments
   _____
   _____

   [ ] Family Support — Contact Name: / Contact Phone:

   Comments:
   _____
   _____

   [ ] Exceptional Education Needs (Special Education-Public Schools) — Contact Name: / Contact Phone:

   Comments:
   _____
   _____

   [ ] Children with Special Health Care Needs — Contact Name: / Contact Phone:

   Comments:
   _____
   _____

   [ ] Any Other Programs? — Contact Name: / Contact Phone:

   Program Name: _____

   Comments:
   _____
   _____

Interviewer: If response was YES to any of the programs, follow-up by asking: *Which of these programs that we just talked about knows most about your child's situation and needs?*

_____
_____

Interviewer: If the answer is YES to question 1 or any YES responses to question 2, please continue to **Part B.**

If the answer is YES to question 1, but NO to 2, referral information should be provided for services in the local community.)

Child Part B: Health And Developmental Needs

1. *Has your child been diagnosed with a specific medical condition?*
   [ ] YES [ ] NO

   If yes, what is the diagnosis?

   _____
   _____
   _____

2. *How often does your child receive program services and/or medical treatment?*

Program Services		Medical Treatment	
[ ]	Daily	[ ]	Daily
[ ]	3 to 4 times per week	[ ]	3 to 4 times per week
[ ]	1 or 2 times per week	[ ]	1 or 2 times per week
[ ]	3 or 4 times per month	[ ]	3 or 4 times per month
[ ]	1 or 2 times per month	[ ]	1 or 2 times per month
[ ]	less than 1 time per month	[ ]	less than 1 time per month
[ ]	Not at all	[ ]	Not at all

   Comments:

   _____
   _____
   _____

3. *How often does your child see a physician?*
   [ ] every week
   [ ] every month
   [ ] more than once a year
   [ ] less than once a year

   Physician's contact information (physician's name, clinic name and phone number):

   _____
   _____

   Type of physician or specialty:

   _____
   _____

   When was your child last seen? Why?

   _____
   _____
   _____

4. *Does your child receive therapeutic or educational services for health care needs such as :*

[ ]	Physical Therapy	[ ]	Mental Health Issues
[ ]	Educational services	[ ]	Occupational Therapy
[ ]	Vision	[ ]	Speech Therapy
[ ]	Hearing Impairment	[ ]	Other _____

What is your role in these services and follow up? How often are you involved in this role?
_____
_____
_____

Child Part C: Daily Living Needs

1. *Does your child have needs (other than what is expected for his/her age) for daily supervision/assistance, such as:*

[ ]	Dressing	[ ]	Communicating
[ ]	Eating	[ ]	Behavior
[ ]	Mobility	[ ]	Forming Relationships/Friendships
[ ]	Breathing	[ ]	Toileting
[ ]	Sleeping	[ ]	Other _____

Comments:
_____
_____
_____

2. *Does your child have need for medical/health treatments, such as:*
   - [ ] G-tubes
   - [ ] Suctioning
   - [ ] Tracheotomy
   - [ ] Medicines
   - [ ] Other _____

Who administers to these needs above, and how often?
_____
_____
_____

What is your role in caring for your child with these treatments and how often is this done?
_____
_____
_____

3. *Does your child require assistive devices for communication, such as:*
   - [ ] Computer
   - [ ] Picture Cards
   - [ ] Sign Language
   - [ ] Hearing aides or other assistive listening devices
   - [ ] Other talking devices

What is your role in using these devices and how often is this done?

_____
_____
_____

4. *Does your child require supervision/assistance with mobility, such as:*
   - [ ] Crutches
   - [ ] Braces
   - [ ] Wheelchair
   - [ ] Special Transportation Monitor
   - [ ] Other _____

   What is your role in meeting your child's needs with these assistive devices and how often?

   _____
   _____
   _____

5. *Does your child receive home health care or other personal care services?*
   [ ] YES [ ] NO

   If yes, please describe the services.

   _____
   _____
   _____

6. *Is your child's care consistent from week to week or does it change frequently with circumstances (e.g., appointments, health status)?*

   _____
   _____
   _____

7. *Are you ever contacted by the school to take your child home due to behavior problems or physical or health problems.*
   [ ] YES [ ] NO

   If yes, how frequently?

   _____
   _____

8. *Looking at this scale, please tell me the number between one and ten that most accurately describes your routine based on your child's special needs.*

   _____

   1 5 10
   Regular and Stable Totally Unpredictable

Child Part D: Child Care Needs

1. *Does your child have any health or behavioral problems that you believe would not allow placement in child care?*
   [ ] YES [ ] NO

Comments:
_____
_____
_____

2. *Does your child require any special accommodations from a child care provider?*
[ ] YES [ ] NO

Comments:
_____
_____
_____

3. *Is the child spending part or all of their day in special programming?*
[ ] YES [ ] NO

If yes, please tell me the schedule.
_____
_____
_____

4. *Has your child ever been, or is your child currently placed in group or family child care?*
[ ] YES [ ] NO

Comment:
_____
_____
_____

5. *Have you ever had problems finding child care?*
[ ] YES [ ] NO

Comment:
_____
_____
_____

6. **Interviewer:** Review with participant the Health and Development Needs from Part B and response to question 3 of this section.

Do you foresee any problems coordinating child care and the other programs identified in question 3, or services described in Part B?
[ ] YES [ ] NO

Comments:
_____
_____
_____

Section II - Adult Family Member With Special Needs

Adult Part A: Health Needs

1. *Has this family member been diagnosed with a specific medical condition?*
   [ ] YES [ ] NO

   If yes, what is the diagnosis

   _____
   _____
   _____

2. *Does this family member receive program services and/or medical treatment (example: DVR, Community Integration Program, Community Supported Living Arrangements, SSI or SSDI)?*
   [ ] YES [ ] NO

   If yes, what type of services is this family member receiving?

   _____
   _____
   _____

3. *How often does this family member receive program services and/or medical treatment?*

Program Services		Medical Treatment	
[ ]	Daily	[ ]	Daily
[ ]	3 to 4 times per week	[ ]	3 to 4 times per week
[ ]	1 or 2 times per week	[ ]	1 or 2 times per week
[ ]	3 or 4 times per month	[ ]	3 or 4 times per month
[ ]	1 or 2 times per month	[ ]	1 or 2 times per month
[ ]	less than 1 time per month	[ ]	less than 1 time per month
[ ]	Not at all	[ ]	Not at all

   Comments:

   _____
   _____
   _____

4. *How often does this family member see a physician?*
   [ ] every week
   [ ] every month
   [ ] more than once a year
   [ ] less than once a year

   Physician's contact information (physician's name, clinic name and phone number):

   _____
   _____

   Type of physician or specialty:

   _____
   _____

   When was this family member last seen? Why?

   _____
   _____
   _____

5. *Does this family member receive therapeutic services for health care needs such as :*

[ ]	Physical Therapy	[ ]	Mental health issues
[ ]	Vision	[ ]	Occupational Therapy
[ ]	Hearing Impairment	[ ]	Speech Therapy
[ ]	Other _____		

What is your role in these services and follow up? How often are you involved in this role?

_____
_____
_____

Adult Part B: Daily Living Needs

1. *Does this family member have needs for daily supervision/assistance, such as:*

[ ]	Dressing	[ ]	Communicating
[ ]	Eating	[ ]	Behavior
[ ]	Mobility	[ ]	Forming Relationships/Friendships
[ ]	Breathing	[ ]	Toileting
[ ]	Sleeping	[ ]	Other _____

Comments:

_____
_____
_____

2. *Does this family member have need for medical/health treatments, such as:*
   - [ ] G-tubes
   - [ ] Suctioning
   - [ ] Tracheotomy
   - [ ] Medicines
   - [ ] Other _____

Who provides the primary care for these needs, and how often?

_____
_____
_____

What is your role in caring for this family member with these treatments and how often is this done?

_____
_____
_____

3. *Does this family member require assistive devices for communication, such as:*
   - [ ] Computer
   - [ ] Picture Cards
   - [ ] Sign Language
   - [ ] Hearing aides or other assistive listening devices
   - [ ] Other talking devices

What is your role in using these devices and how often is this done?

_____
_____
_____

4. *Does this family member require supervision/assistance with mobility, such as:*
   - [ ] Crutches
   - [ ] Braces
   - [ ] Wheelchair
   - [ ] Special Transportation Monitor
   - [ ] Other _____

   What is your role in meeting this family member's needs with these assistive devices and how often?

   _____
   _____
   _____

5. *Is this family member's care consistent from week to week or does it change frequently with circumstances (e.g., appointments, health status)?*

   _____
   _____
   _____

6. *How are this family member's daily care needs met when normal services are not available, for example, on holidays or weekends?*

   _____
   _____
   _____

7. *Looking at this scale, please tell me the number between one and ten that most accurately describes your routine based on this family member's special needs.*

   _____

   1 5 10
   Regular and Stable Totally Unpredictable

Section II Adult Summary:

_____
_____
_____
_____