

**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
Comprehensive Assessment: A Guide to Conversation

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.

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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: _____

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Identifying Information

Child/Youth:	_____				
DOB:	_____	Age:	_____	Gender:	_____
MaineCare #:	_____		Social Security #:	_____	
Address:	_____				
City:	_____	State:	_____	Zip:	_____
Own Guardian:	<input type="checkbox"/> Yes <input type="checkbox"/> 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):	_____	

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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:	_____		

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Contact List

Mother:				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Father:				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Guardian (if not parent):				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Other Parenting Figure (foster parent, kinship care etc.):				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Extended Family Member(s) or Natural Supports:				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Extended Family Member(s) or Natural Supports:				
Name: _____				
Address: _____				
Phone : _____		Phone: _____		Email: _____
Release completed: <input type="checkbox"/> Yes		Release expires: _____		
Siblings:				
Name	Age	Live with Child:	Release Complete	Release Expires
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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Services

Case Management Agency: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Primary Care Doctor: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Other Doctor: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Therapist: <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Speech and Language <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Therapist: <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Speech and Language <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
School _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Child Care Provider: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____
Other Provider: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Release completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Release expires: _____

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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:

Has there been a recent change in the child's sleep pattern? Yes No

Does your child: Yes No

• Sleep through the night?

• Have nightmares?

• Take naps?

Do you have concerns about your child's sleep patterns?

Explain:

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Physical Complaints:

Does your child have:	Yes	No
• Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
• Frequent stomach aches?	<input type="checkbox"/>	<input type="checkbox"/>
• Frequent muscle pain?	<input type="checkbox"/>	<input type="checkbox"/>
• Frequent itching?	<input type="checkbox"/>	<input type="checkbox"/>
• Other?	<input type="checkbox"/>	<input type="checkbox"/>

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

Do you have other concerns about your child's health?

If yes, please explain:

Child's Developmental History

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? _____

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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 <input type="checkbox"/> | Preschool <input type="checkbox"/> | Public Pre-K <input type="checkbox"/> |
| Home School <input type="checkbox"/> | Public School <input type="checkbox"/> | Private School <input type="checkbox"/> |
| Other: <input type="checkbox"/> | _____ | |

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	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Low	<input type="checkbox"/>
Emotional Reactions:	Strong	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Minimal	<input type="checkbox"/>
Emotional Recovery Time:	Long	<input type="checkbox"/>	Average	<input type="checkbox"/>	Short	<input type="checkbox"/>

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 Strengths:

Area of Concerns:

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Self-Awareness:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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?			
What else is important to you about your child's managing emotions?			

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Non-Verbal Relationship Skills:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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?			

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Interpersonal:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never</i>	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:			
<i>Rating Scale Varies:</i>	Date	Date	Date
Does your child have <i>1-Lots of friends; 2-Few friends; 3- No friends</i>			
Does your child have a best friend? <i>1-Yes; 2-No</i>			
Is your child picked on/bullied by other children? <i>1-Never; 2-Sometimes; 3-Frequently</i>			
Does your child pick on/bully other children? <i>1- Never, 2- Sometimes, 3-Frequently</i>			
What else is important to you about your child's friendships?			

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

<p>Social Functioning Summary</p> <p>Areas of Strength:</p> <p>Areas of Concern:</p>
--

Behavioral Functioning

Consider the developmental ability of the child when responding.

Safety:			
	Date	Date	Date
<i>Rating Scale: 1 – Always; 2 – Most of the time; 3– Sometimes; 4 – Rarely; 5 – Never</i>			
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?			

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Attention:				
How many minutes can your child focus at a time on something interesting?	<input type="checkbox"/> < 5	<input type="checkbox"/> 10-15	<input type="checkbox"/> 30	<input type="checkbox"/> Other
How many minutes can your child focus at a time in something not interesting?	<input type="checkbox"/> < 5	<input type="checkbox"/> 10-15	<input type="checkbox"/> 30	<input type="checkbox"/> Other
How would you describe your child's level of distractibility?	<input type="checkbox"/> 1 Low	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3 High	
After being distracted, your child returns to a task	<input type="checkbox"/> 1 Easily	<input type="checkbox"/> 2 Needs help	<input type="checkbox"/> 3 Cannot refocus	
What distracts your child? <input type="checkbox"/> Sounds <input type="checkbox"/> Sights <input type="checkbox"/> Touch <input type="checkbox"/> People <input type="checkbox"/> Other <input type="checkbox"/> Specify:				
How would you describe your child's ability to tolerate frustration? <input type="checkbox"/> 1- High <input type="checkbox"/> 2- Moderate <input type="checkbox"/> 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:			
<i>Rating Scale:</i> 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:			
<i>Rating Scale:</i> 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			

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Does your child injure him/herself? Yes No

If yes, describe how and how often:

Physical Aggression:			
<i>Rating Scale:</i> 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

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Functional Life Skills- Activities of Daily Living

Consider the developmental ability of the child when responding.

Communication:			
	Date	Date	Date
<i>Check all that apply</i>			
How does your child communicate?			
• Verbally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• With the help of adaptive equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Explain:			
<i>Rating Scale: 1 – Always; 2 – Most of the time; 3 – Sometimes; 4 – Rarely; 5 – Never</i>			
	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:			
<i>Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others</i>	Date	Date	Date
Does your child:			
• Walk?			
• Perform gross motor skills?			
• Perform fine motor skills?			
• Use adaptive equipment?			
Physical Total			

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

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

Time Awareness:			
<i>Rating Scale: 1 – Always; 2 – Most of the time; 3 – Sometimes; 4 – Rarely; 5 – Never</i>	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?			

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

Home Living Skills:			
<i>Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others</i>	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?

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

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Comprehensive Assessment: A Guide to Conversation

Money:			
<i>Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others</i>	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: Checking <input type="checkbox"/> Savings <input type="checkbox"/> Both <input type="checkbox"/>			
Money Total			
Does your child need a representative payee? <input type="checkbox"/> Yes; <input type="checkbox"/> 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?