Demographic Screen

*Intake Coordinator:	
Primary/Ongoing Coordinator:	
*Child's Name:	
Social Security #:	
*Date of Birth:	
*Gender:	
Ethnicity / Race:	◯ Hispanic/Latino ◯ Asian ◯ Black/African American ◯ American Indian/Alaska ◯ Native ◯ Native Hawaiian/Other ◯ Pacific Islander ◯ White ◯ Two or more races **(Warning: You could save page without Race, but will need it before you can develop an IFSP)** (Instruction: Ask, Do you identify your child as Hispanic/Latino? If parent says yes, this is the only response needed. Mark it and skip to #6. If parent says no, ask them to choose from among the remaining choices.)
*Child's Residence (address):	
2nd Residence (address):	
Language Used at Home:	◯ Interpreter Needed ◯ Interpreter Waived
Preferred Language/Instruction:	
Current LEA:	
Parent Restriction of Rights?	◯ Mother ◯ Father Reason?
Does this child have an open case with DSS/CPS?	◯ Yes ◯ No
Is child currently in home or out of home?	◯ In home ◯ Out of home?
Child requires educational surrogate parent?	◯ Yes ◯
Household member names and relationships:	
Comments:	
*Emergency Contacts (other than parents/guardians)	***Contact 1:** Name- Home Phone- 2nd phone- Email- Note-
	***Contact 1** Name- Home Phor 2nd phone- Email- Note-

Restrictions are only indicated when the service coordinator has documented legal proof.

Children are considered "in home" unless they have legally been taken out of their home and placed in foster care or family placement.

Referral Screen

*Referral Date:	
Referral Acknowledgement Date:	
Reason for Referral:	
Is there a developmental Concern?	
*Referral Source:	Agency/Relationship to Child: Name/Agency: Phone: Address: Email: How did the referral source hear about BabyNet?
*Previous Screenings	◯ Communication ◯ Hearing ◯ Motor ◯ Overall Development ◯ Social/Emotional ◯ Vision ◯ Autism ◯ N/A
Previous Services and Providers:	
Previous Screening/Service Comments:	
Parents have consented for the following agencies to receive child specific data:	◯ DHEC/Children with Special Healthcare Nee ◯ Early Head Start ◯ EDHI/First Sound ◯ Local School/Lead Education Agency ◯ Primary Care Physician as recorded on Heal ◯ SSI/Disability ◯ State Longitudinal Data System
Comments on Release of Informa	
*Referral Initial Contact Attempt Date: (mm/dd/yyyy)	
*Referral Actual Contact Date: (mm/dd/yyyy)	
*Intake Visit Date: (mm/dd/yyyy)	
Comments:	

Referral Acknowledgement date is the date that SPOE sent a letter to the referral source thanking them for the referral.

Previous screenings, services, and providers refers to screenings or services a child received prior to their referral to BabyNet. If no previous screenings, select N/A.

New information to be collected at Intake.

Referral Initial Contact Attempt: The first time SPOE attempted to contact the family. If the family made the referral, this is the same as the referral date. **Referral Actual Contact Date:** The date SPOE actually talked to the family the first time. This could be the same as the referral date or the same as the attempted date. *Attempted, Actual, and Intake dates must be entered prior to entering eligibility information on Eligibility screen.*

Health Screen

Health Information

*Primary Physician/Healthcare Provider (name, address, phone):	
Other Physician/Healthcare Providers (name, specialty, phone):	
Medication/Equipment:	
Emergency Factors:	
Bacterial Meningitis?	◯ Yes ◯ No If yes, flag for audiological screen.
Family History of Early Onset Hearing Loss?	◯ Yes ◯ No If yes, flag for audiological screen.
Severe Head Trauma?	◯ Yes ◯ No If yes, flag for audiological screen.
Prolonged Otitis Media and/or Middle Ear Fluid Greater than 2 Months?	◯ Yes ◯ No If yes, flag for audiological screen.
Gender:	◯ Male ◯ Female
Syndromes Associated with Hearing Loss (Flag for Audiological Screen):	◯ Agenesis of the Corpus Callosum ◯ Brachmann-De-Lange Syndrome ◯ Crouzon Syndrome ◯ Hearing Loss > 20 dB ◯ Kneist Dysplasia ◯ Neurofibromatosis 2 ◯ Stickler Syndrome ◯ Auditory Atresia ◯ Branchiootorenal (BOR)/Meinick-Fraser ◯ Goldenhar Syndrome ◯ Jackson Weiss Syndrome ◯ LADD Syndrome ◯ Norrie Disease ◯ Waardenburg Syndrome ◯ Auditory Neuropathy ◯ Cleidocranial Dysplasia ◯ Hajdu Cheyney Syndrome ◯ Kearnes-Sayne Syndrome ◯ Microtia ◯ Perrault Syndrome
Syndromes Associated with Vision Loss (Flag for Vision Screen):	◯ Albanism ◯ Bilateral retinal detachment w/ Blindness ◯ Cortical Blindness ◯ Mobius Syndrome ◯ Retinoblastoma ◯ Stickler Syndrome ◯ Anophthalmia ◯ Optic Nerve Atrophy ◯ ROP stages 4 and 5 ◯ Bilateral Optic Nerve Coloboma ◯ Cataracts w/ visual impairment ◯ Lebers amaurosis ◯ Retinitis pigmentosa ◯ Septo-optic dysplasia ◯ Bilateral Visual Acuity <20/70 corrected vision best eye ◯ Glaucoma with visual impairment

Please list each doctor's name, specialty, and phone number.

Use information gathered from the Hearing & Vision Questionnaire to complete these fields.

Health Comments:	
Birth Information	
Birth Weight:	_____lbs _____oz (_____ grams) (if less than 3 lbs 4.8 oz, flag for audio screen)
Birth Length:	_____ inches
Gestational Age	_____ weeks gestation (if less than 34 weeks, flag for audio screen)
Multiple Birth	◯ Yes ◯ No
Special Considerations	◯ Bilirubin = 20 mg per dl ◯ Birth defects involving craniofacial structure (i.e. ear anomaly ◯ Brain Bleeds ◯ Breathing Difficulties ◯ Breech Birth ◯ Congenital Infection (i.e. cytomegalovirus, herpes, toxoplasmosis) ◯ Cord around neck ◯ C-Section Birth ◯ Delayed Crying ◯ Feeding Difficulties ◯ Forceps/Vacuum Extraction ◯ Jaundice ◯ Low Birth Weight (<1200 gram) ◯ Meconium Staining ◯ Other ◯ Prematurity (< or = 28 weeks gestational age) ◯ Seizures ◯ Surgeries
Birth Comments:	
Pregnancy Information	
Which pregnancy is this?	(1, 2, 3, 4, 5, 6, other)
Month of Pregnancy in which routine prenatal care began?	1, 2, 3, 4, 5, 6, 7, 8, 9
Pregnancy Complications/Illnesses:	◯ Alcohol Use ◯ Anemia ◯ Bleeding ◯ Chronic Disease ◯ Elevated Blood Pressure ◯ Gestational Diabetes ◯ Illegal Drug Use ◯ Infections ◯ Over the Counter Drug Use ◯ Physician Ordered Bed rest ◯ Prescription Drug Use ◯ Pre-term Labor ◯ RH Incompatibility ◯ Tobacco Use ◯ Toxemia/Preeclampsia ◯ Trauma ◯ Vomiting
Medication Taken During Pregnancy:	
Pregnancy Comments:	

Parent Screen

Parent/Guardian One Information:

*Name:	◯ Same address as Child
Relationship to Child:	
Mailing Address:	
Phone: Home: Work: Cell:	
Email:	
Occupation:	
Employer:	
Highest Level of Education:	
Date of Birth:	
Parent One Comments:	

Parent/Guardian Two Information:

Name:	◯ Same address as Parent One
Relationship to child:	
Mailing Address:	
Phone: Home: Work: Cell:	
Email:	
Occupation:	
Employer:	
Highest Education Level:	
Date of Birth:	
Parent Two Comments:	

Selecting these boxes will prepopulate certain demographic fields related to the parents.

Financial Support Screen

*Current Family Financial Support/Services:	◯ CCSHCN/Title V ◯ Early Childhood Mental Health ◯ Early Head Start ◯ Home Health ◯ Hospice Services ◯ Medicaid Managed Care ◯ Medicaid Waiver ◯ Medicaid/EPSDT ◯ Medicare ◯ Neonatal Follow-up Clinic ◯ None Besides Early Intervention ◯ PI… Injury Trust Fund ◯ TRICARE ◯ WIC

Medicaid Waiver-TEFRA, Medicaid/EPSTD-Fee for Service

Primary Insurance:	
*Insurance Company:	*Policyholder's Name:
*Policy #:	*Policyholder's Relationship to Insured:
*Insurance Effective Date: (MM/DD/YYYY):	*End Date:
*Group #:	*Policyholder's Employer:
*Phone # for Claims:	*Policyholder's DOB:
*Latest Insurance Verification:	
*Address:	
Secondary Insurance:	
Insurance Company:	Poli…
Policy #:	Poli…
Insurance Effective Date: (MM/DD/YYYY):	End…
Group #:	Poli…
Phone # for Claims:	Poli…
Latest Insurance Verification:	
Address:	

If there is no private insurance, leave primary and/or secondary insurance blank. If there is private insurance, you must provide all * items. If you do not have the information, put in a placeholder, note it at the bottom of this screen, and fill in the correct data after you have gathered the information from the policyholder. ***Information must be correct for billing claims. Claims will be denied if this information is not correct.***

Medicaid			
Medicaid #:			
Medicaid Choice: (circle one)	**Managed Care:** Absolute Total Care, BCBS Health Plan, First Choice, Well Care **Medical Home Network:** Carolina Med. Homes, Pal. Physicians Conn., S.C. Solutions		
Medicaid Ineligible Period:	_____to_____	_____ to _____	_____ to _____
Comments:			

Annual Household Income:	◯ Family Refuses Income Verification
Proof of Income:	
Household Size:	
Siblings in EI System:	
Family Share:	
Not Billable Due to:	◯ Sibling in EI ◯ Bankruptcy ◯ Low Income ◯ Temporary Suspension ◯ N/A
NOTE:	

Screening Screen

*Date Screening Received/Conducted:

Child's Chronological Age:	Child's Adjusted Age:
*Informant Name:	Relationship to Child:

Screening Procedures:	◯ Parent/Guardian Interview w/ Staff Assistance ◯ Screening Received from other source ◯ Parent/Guardian completed w/o staff assistance ◯ Other (explain in note)	
Previous Screening History-Completed as needed	Screening Agency 1:	Date
	Screening Agency 2:	Date of Scre

This is the person who gave information to help complete the screening tool (family member, teacher, etc.)

Name of Professional if not First Steps:

Screening Tool 1:	Screening Tool 2:

ASQ-III: Questionnaire Used (12m, 14m, 24m, etc.): _____ months

AREA	Total Score	Scores in Black Area	Scores in Gray Area	Scores in White Area
Communication		◯	◯	◯
Gross Motor		◯	◯	◯
Fine Motor		◯	◯	◯
Problem Solving		◯	◯	◯
Personal-Social		◯	◯	◯

Summary of Questions 1-9 from score sheet:

ASQ-SE: Questionnaire Used (12m, 14m, 24m, etc.) _____ months

AREA	Total Score	At Risk	No Concern
Social-Emotional		◯	◯

Autism Screening: M-CHAT: ◯ Passed ◯ Indicates Risk- 3 non-critical items
◯ Indicates Risk- 2 critical items ◯ F/U Interview Indicates Risk ◯ Stat Passed ◯ Stat Indicates Risk

Scores/Results of other screeners(If applicable):

Actions:	◯ Screening shows potential concern(s), referred for Eligibility Evaluation ◯ Screening shows potential concerns, family chooses not to proceed (This would bring you to the transition page, please choose 'Parent Withdraw' as the exit reason) ◯ Screening passed but referred for Eligibility Evaluation due to parent request ◯ Screening passed but referred for Eligibility Evaluation due to professional judgment/ICO. ◯ Screening Passed, Discharge (This would bring you to the transition page, please choose 'Screening Passed' as the exit reason) ◯ Screening shows potential concerns, referred for further Autism Screening and Assessment Date Letter Sent: (mm/dd/yyyy)

Note:

Evaluation/Assessment Information

Health:

Established Risk Condition and/or Other Health

◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

E/R Diagnosis Code:

Other Diagnosis Codes:

*Date of Verification of medical report (including E/R diagnosis if any)

Child Health Status: ◯ No Concern ◯ Minor Concern ◯ Major Concern

Clinical Observations:

Verified By:

Recommendations:

Notes:

Health information should be collected on all child cases to determine eligibility. Child can't be determined eligible based on **Established Risk** unless their Health Assessment is completed.

The date that the child's health information was received and reviewed by SPOE for BabyNet eligibility.

The BabyNet professional who received and reviewed the documentation that verified the diagnosis.

Hearing:

◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

Verification Date: ◯ Is there a Hearing Concern?

Screening Method:

*Clinical Observations:

Screened By:

Recommendations:

Notes:

Only required if there was hearing screening/assessment/evaluation.

Vision:

◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

Verification Date: ◯ Is there a Vision Concern?

Screening Method:

*Clinical Observations:

Screened By:

Recommendations:

Notes:

Only required if there was vision screening/assessment/evaluation.

5 Area Evaluation/Assessment:

◯ Initial ◯ Ongoing Assessment ◯ Re-Eval

*Evaluation/Assessment Completed Date:

Evaluation Instrument:

Assessment Method:

Evaluator:

Environment, Health, and Behavioral Observations:

If eligible based on Established Risk- Use 5AA to record CBA information. If eligible based on Developmental Delay (and a BDI was done by SPOE)-enter BDI as 5AA (see specialty assessment note for more info). For re-evaluation, CBA report should be entered as a 5AA.

Domain Specific Information:

Self Help (Adaptive)

Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:

Clinical Observations:

Notes:

Scores: For each domain, give the score yielded by the evaluation/assessment tool. HELP and Carolina- % of delay range, BDI- Developmental Quotient, AEPS- put scores in Notes section. **Clinical Observations:** Summarize the current skills, emerging skills, and skills not yet learned.

Social Emotional

Developmental Age: _____to_____	
Standard Deviation:	
Clinical Observations:	

Notes:

Communication

Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:

Clinical Observations:

Notes:

Motor

Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:

Clinical Observations:

Notes:

For tools that split motor into Gross and Fine motor, do not give an overall score. List the Fine motor and Gross motor scores separately in the Notes field.

Cognitive

Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:

Clinical Observations:

Notes:

Summary Information:

Specialty Assessment:

◯ Initial ◯ Ongoing Assessment ◯ [illegible] Evaluation

*Evaluation/Assessment Completed Date:

Evaluation Instrument:

If 5AA was the BDI and a CBA was administered prior to the initial IFSP, enter that CBA as a Specialty Assessment.

Assessment Method:
(Direct, Observation, Parent Report)

Evaluator:

Clinical Observations:

List each domain and the domain score

Environment, Health, and Behavioral Observations:

Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Develo[illegible]re:

Recommendations:

Summarize the skills the child is not yet demonstrating (0, -)

Notes:

Summarize the skills the child IS currently demonstrating or skills that are emerging (1,2, +, +/-)

Eligibility Screen

◯ Established Risk (Must enter diagnosis in Evaluation/Assessment Screen->Health)

◯ Developmental Evaluation

*Part C Eligible Decision: ◯ Eligible ◯ Ineligible	*Determination Date:

Ineligible Reason:

Comments:

IFSP Outcome Screen

◯ Child ◯ Family ◯ Transition *Target Date_____

*Outcome	*Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

Natural Supports: Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and

Review section used when outcomes are reviewed at 6 month and Change Review

◯ Child ◯ Family ◯ Transition *Target Date_____

*Outcome	*Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

◯ Child ◯ Family ◯ Transition Target Date_____

Outcome	Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

Planned Services

Outcome # (s)_____ *Start

Service coordinator always notes which outcome (s) the service will address

Select if family permits the use of Insurance and Medicaid (signed form should be in hard copy of chart) and if the family accepts the service

◯ Accept Service
◯ Permit Insurance
◯ Permit Medicaid

*Service Name	*Provider	*Method of Delivery	*Intensity	*Setting
			◯ Consultation ◯ Individual	

*Frequency	*Length	*Payor	
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____	

Select the method and setting the provider most often uses.

Planned

Outcome # (s)_ d Date _____

SC: 1 x semiannually for 20 hours

SI: 1 x Month for 4 hours (this will allow SI to make up FT visits by adding additional time to regularly scheduled visits if that is what the parent requests)

Service coordinator should ensure that Part C is always the payor of last resort. Private insurance is always first (if available and authorized), then Medicaid (if available and authorized), and last is always Part C.

Service Name	of Delivery	In	
		◯ Con ◯ Individual	

Frequency	Length	Payor	Justification for non-nat. environment	Note
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____		

Planned Services

Outcome # (s)_____ Start Date_____ End Date _____

◯ Accept Service
◯ Permit Insurance
◯ Permit Medicaid

Service Name	Provider	Method of Delivery	Intensity	Setting
			◯ Consultation ◯ Individual	

Frequency	Length	Payor	Justification for non-nat. environment	Note
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____		

IFSP Screen

*IFSP Meeting Date:	IFSP Delay Reason:
*IFSP Type:	
Informed Parental Consent:	
Parent/Guardian(s) is Legal Guardian?	◯ Yes ◯ No
Parent/Guardian(s) has parental rights as defined under Part C Regulations?	◯ Yes ◯ No
Parent/Guardian(s) participated in development of the IFSP?	◯ Yes ◯ No
Parent/Guardian(s) agreed to IFSP implementation?	◯ Yes ◯ No

Family Assessment Parent Interview Date: _____

Family Concerns:

This information can be found in Section 7 of the current IFSP.

Family Resources and Supports:

Family Priority:

Identification of Natural Environments:

*Other Services:

This information can be found in Section 9 of the current IFSP.

*IFSP Participants:

◯ Assessor(s) ◯ Child Care Provider ◯ CPS Worker ◯ First Steps County Partnership
◯ 5 Area Evaluator/Assessor ◯ Physician ◯ Potential Direct Service Provider ◯ Service Coordinator

IFSP Participants Detail:

IFSP Meeting Note:

This information can be found in Section 14 of the current IFSP.

Service Log

*Service:

*Actual or Missed Service Date	*Service Delivery Status	*Start Time	*End Time	CPT/HCPCS Code
***ICD Code**	**TCM Category**	***Service Note/Description of Intervention**		**Correction/ Addendum**

Service log must be entered within 10 days of service delivered.

Service Log

Service:

Actual or Missed Service Date	Service Delivery Status	Start Time	End Time	CPT/HCPCS Code
ICD Code	**TCM Category**	**Service Note/Description of Intervention**		**Correction/ Addendum**

Service Log

Service:

Actual or Missed Service Date	Service Delivery Status	Start Time	End Time	CPT/HCPCS Code
ICD Code	**TCM Category**	**Service Note/Description of Intervention**		**Correction/ Addendum**