VERMONT

AGENCY OF HUMAN SERVICES

CHILDREN'S PERSONAL CARE SERVICES
VERMONT DEPARTMENT OF HEALTH
280 State Drive
Waterbury, VT 05671-8360
800.660.4427

Instructions for completing Intake Form for use with Children's Personal Care Services Functional Ability Screening Tool

- ✓ Intake Form must be completed by an evaluator who has successfully completed training on both the IFS Intake Form and Children's Personal Care Services Functional Ability Screening Tool (i.e., by an evaluator who is included in the Children's Personal Care Services Assessor Directory)

- ✓ Intake Form can be completed with the family (in person, over the phone, or through collateral contact). Demographic (or intake) portion of the IFS Intake Form can be completed directly by the family in advance. It is not appropriate for the family to complete non-demographic portions of the Intake Form directly nor is it appropriate for the family to complete any portion of the Children's Personal Care Services Functional Ability Screening Tool.

- ✓ The child (applicant) must be present—and participate—in the Children's Personal Care Services application process. Applications where the child is not present or does not participate are considered incomplete and cannot be submitted for review. How the child participates may take different forms depending on the child's tolerance level for such activities. HOWEVER, it is important to have an opportunity for the assessor to interact with the child on some level.

- ✓ To apply for Children's Personal Care Services, an Intake Form, Children's Personal Care Services Functional Ability Screen and Children's Personal Care Services Care Plan must be completed. Please include supplemental information—such as Child Development Clinic report, psychological evaluation, Individualized Education Plan/Section 504 Plan, hospital/residential treatment facility discharge plans, physician notes. For new applicants, diagnosis verification must be included.

- ✓ Missing or incomplete information may result in delayed processing, returned applications, or a denial of services. Please take care to provide complete and accurate information.

❖ **Send complete applications to:**

Secure Email: **AHS.VDHChildrensPersonalCareSvs@vermont.gov**

Secure Fax: **802.863.6344**

USPS:
Vermont Department of Health
Children with Special Health Needs
280 State Drive
Waterbury, VT
05671-8360

Application Submission Checklist

Before sending in a CPCS Application, have you included a completed:

- ☐ CPCS Intake Form
- ☐ CPCS Functional Assessment Screening Tool (FAST)
- ☐ CPCS Care Plan
- ☐ Recent Supplemental Documents such as: IEP or 504 Plan, psychological evaluation, Well Child Notes from a physician's visit (completed within 3 years)
- ☐ **FOR NEW APPLICATIONS ONLY:** ICD-10 Coding/Diagnosis Verification Form completed by treating provider.

A. Demographic Information

1) Basic Information for whom services are being applied			
*First Name		*Last Name	
*Gender ☐ Male ☐ Female ☐ Non-Binary	Unique Identifier/Medicaid ID #	Date of Birth	Age
*Physical Address			
*City	*State	County	*Zip
Mailing Address, if different			Primary Diagnosis (including ICD-10)

2) Assessor's Name and Organization		
*Name and Organization		*Intake Date
*Mailing Address		*Telephone Number
*City	*State	*Zip

3) Referral Source: (Check only one option)

☐ Self/family
☐ Legal Guardian
☐ Self
☐ Social Worker
☐ School/Preschool
☐ PICU/NICU
☐ Childcare Provider
☐ DCF—Family Services
☐ Physical Therapist, Occupational Therapist, or Speech Language Pathologist
☐ Children's Integrated Services (CIS) Team
☐ Primary/Specialty Care Provider
☐ Designated Developmental/Mental Health Agency or Specialized Services Agency (please indicate)
☐ Children's Personal Care Services Re-evaluation Notice
☐ Other (please specify):

***Primary Concern/Reason for Referral:**

4)* Is the child in Department of Children and Family—Family Services (DCF) custody?

☐ Yes ☐ No ☐ **If appropriate, DCF is aware of intake/referral?**

If yes, Department of Children and Family—Family Services Worker Contact Information

5) Current Residence

☐ With Parent(s)
☐ Shared Physical Custody between Parents
☐ With Other Unpaid Family Member(s)
☐ With Legal Guardian
☐ Alone (includes person living alone receiving in-home services)
☐ DCF-Family Services Foster Care
☐ Shared Living Provider
☐ Homeless
☐ Hospice Care Facility
☐ ICF-DD
☐ Nursing Home—Rehabilitation Facility
☐ Nursing Home
☐ In-State Residential Treatment Facility
☐ Out-of-State Residential Treatment Facility
☐ Hospital
☐ Juvenile detention/jail
☐ With spouse/partner/roommate
☐ Other (please specify):_____

6a) *Parent/Guardian Contact Information (Primary Caregiver)
(If both parents reside at same address, please complete jointly)

***Relationship (check only one option):**
☐ Parent(s) (Biological)
☐ Parent(s) (Adopted – complete #8)
☐ Legal Guardian
☐ Foster Parent(s)
☐ Shared Living Provider
☐ Spouse/Partner
☐ Other (please specify):
_____

*First Name *Last Name

*Address Mailing Address, if different

*City *State *Zip

* Telephone Number(s)

6b) Other Adult (Parent/Guardian) Contact Information (Secondary Caregiver)	
Relationship (check only one option): ☐ Parent (Biological) ☐ Parent (Adopted – complete #9) ☐ Legal Guardian	☐ Foster Parent ☐ Shared Living Provider ☐ Other (please specify): _____
First Name	Last Name
Address	Mailing Address, if different
City	State Zip
Telephone Number(s)	

7) What is the family's primary language? (check only one option)		
☐ English ☐ Arabic ☐ Burmese ☐ Dinka ☐ French ☐ Napali	☐ Serbo-Croatian ☐ Somali ☐ Spanish ☐ Swahili ☐ Russian ☐ Vietnamese	☐ American Sign Language/TTY-Relay Service ☐ Other (please specify): _____ **Does the primary care giver have Limited English Proficiency?** ☐ Yes ☐ No **Is an interpreter required?** ☐ Yes ☐ No

8) Has this child been adopted?	☐ **No** ☐**Yes, if yes, when? (year)**
Is the family connected with post-adoption services?	☐ No ☐Yes, if yes, what agency?

☐ **Is the child/family receiving post-adoption case management? If yes, please indicate organization, case manager and contact number.**

☐ **Is the family receiving an adoption subsidy? Level of support?**

B. Household Information

1) Family Composition (list all the people who currently live in your child's home, excluding the child)			
First and Last Name	Date of Birth	Sex (M/F)	Relationship to child
List the parents and/or siblings who do not currently live in your child's home			
First and Last Name	Date of Birth	Sex (M/F)	Relationship to child

2) Agency of Human Services Indicators		
Does the family have:		
Safe, secure housing?	☐ No	☐ Yes
Concerns about the child(ren)'s safety	☐ No	☐ Yes
Active involvement in the criminal justice system?	☐ No	☐ Yes

Agency of Human Services Indicators (cont'd)		
Is the home environment free of abuse, neglect and/or exploitation?	☐ No	☐ Yes
Is the parent interested in information regarding nutrition programs (WIC, 3-Squares, etc.)	☐ No	☐ Yes
Is the parent interested in information related Economic Services program (fuel assistance, ReachUp, etc.)	☐ No	☐ Yes
Do(es) the parent(s) have a primary physician	☐ No	☐ Yes
Does the parent have any health concerns:	☐ No	☐ Yes

Additional Information regarding AHS Indicators

3) Narrative regarding family strengths, challenges, and resiliency factors

C. Health Information for the Child

1) Private Insurance Information (include policy number and clearly write numbers)		
Company Name & Policy Number	Policy Holder's Name	Individual Number
Company Name & Policy Number	Policy Holder's Name	Individual Number

2) List the hospitalizations, surgeries or medical procedures (i.e., MRI, CT Scan, EEG) within the last 12-18 months (include supplemental materials as appropriate)		
Date	Location/Provider	Reason for hospitalization or procedure

Health Care Provider Contact Information (add additional pages as needed)

3) *Medical Home/Primary Physician			
Date of Last Visit:_____		Date of Next Scheduled Visit: _____	
*Physician's First Name		*Physician's Last Name	
*Address (including Group/Practice Name, if applicable)			
*City	*State	*Zip	*Telephone Number

3a) Dentist			
Date of Last Visit:_____		Date of Next Scheduled Visit: _____	
First Name	Last Name		
Address (including Group/Practice Name, if applicable)			
City	State	Zip	Telephone Number

Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit:_____		Date of Next Scheduled Visit: _____	
Area of Specialization:			
First Name	Last Name		
Address (including Group/Practice Name, if applicable)			
City	State	Zip	Telephone Number

Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit:_____		Date of Next Scheduled Visit: _____	
Area of Specialization			
Specialist's First Name	Specialist's Last Name		
Address (including Group/Practice Name, if applicable)			
City	State	Zip	Telephone Number

Specialty Provider (including complimentary/alternative provider)			
Date of Last Visit:_____		Date of Next Scheduled Visit: _____	
Area of Specialization			
Specialist's First Name	Specialist's Last Name		
Address (including Group/Practice Name, if applicable)			
City	State	Zip	Telephone Number

Diagnostic Information

4) Medical Problem List (each specialty service reserves the right to verify diagnosis, per specific policy)
If the child has been diagnosed with any medical, developmental or psychiatric conditions, please list below (include the diagnosing professional and date of diagnosis).

D. Skilled Care Needs

1) Health Care Needs Related to:	
	Expected to last for at least 6 months
☐ Rehabilitation program for brain injury or coma (minimum of 15 hr/wk)	☐ Yes ☐ No
☐ Wound, site care or special skin care (please specify): ☐ One hour a day or less ☐ More than 1 hour/day	☐ Yes ☐ No
OSTOMY CARE	☐ Yes ☐ No
DIALYSIS (home vs. outpatient)	☐ Yes ☐ No
OXYGEN dependence and delivery (nasal cannula, CPAP, BiPAP, ventilator)	☐ Yes ☐ No
URINARY CATHETER	☐ Yes ☐ No
IV ACCESS	☐ Yes ☐ No
MEDICATION MANAGEMENT **Must include current medication list and schedule**	☐ Yes ☐ No

E. Emotional and Behavioral Challenges

Pediatric Symptom Checklist-17

1) Does the child experience challenges with attention, such as:			
	Never	Some	Often
Fidgety, unable to sit still			
Daydreams too much			
Distracted easily			
Has trouble concentrating			
Acts as if driven by a motor			
2) Does the child:			
	Never	Some	Often
Feel sad, unhappy			
Feel hopeless			
Is down on him/herself			
Worry a lot			
Seem to be having less fun			
3) Does the child:			
	Never	Some	Often
Fight with others			
Not listen to rules			
Not understand other people's feelings			
Tease others			
Blame others for his/her troubles			
Refuse to share			
Take things that do not belong to him/her			

Notes:

F. Additional Health Information (add additional pages as needed)

Additional information related to the child's *recent* health status (within the last 12-18 months), including any hospitalizations or rehabilitative placements. Please include previous screens or evaluations performed.

G. Supports Information for the Child

	Previously Received	Currently Receiving
HEALTH SERVICES		
Pediatrician/Primary Care Physician (Medical Home Practice)		
Physical Therapy		
Occupational Therapy		
Speech/language Therapy		
Home Health Services		
Nutrition Support		
Hearing Support		
Vision Support (Division for Blind and Visually Impaired Services)		
Communication Support		
Service Coordination/Case Management (please specify provider) ☐ Medical Home ☐ Children's Mental Health/Developmental Services ☐ Home Health Agency ☐ Vermont Department of Health—Children with Special Health Needs		
Other:		

Is the child actively enrolled in school (including private, alternative and home schooling)?
☐ Yes, if yes, what grade? ☐ No
School Name, City, State
School Case Manager's Name (or Teacher, if appropriate) and Telephone Number

Is child's school attendance significantly affected (i.e., misses at least 50% of school, has an alternate school day or has home tutoring) by his/her condition(s)?
☐ No ☐ Yes, if yes, please indicate how

	Previously Received	Currently Receiving
EDUCATION SERVICES (Agency of Education)		
Early Essential Education (EEE)		
Section 504 Plan		
Individual Education Plan (IEP) (Special Education)		
Coordinated Services Plan (Act 264 Plan)		
IEP Transition Plan		
Division of Voc. Rehabilitation		
Other:		
OUT-OF-SCHOOL TIME SERVICES (School-age Children/youth)		
After School Services/Tutor		
Child Care ☐ DCF Subsidized ☐ CDD- Accommodations Grant		
Summer and/or School Vacation Camps		
Other:		
CHILDREN'S INTEGRATED SERVICES-EARLY CHILDHOOD (CIS-EI) (Department for Children and Families)		
Children's Integrated Services (ages 0-6)		
Child Care/Early Childhood Program/Pre-school ☐ DCF Subsidized ☐ CDD- Accommodations Grant		
Early Head Start		
Head Start		
Other:		

	Previously Received	Currently Receiving
CHILDREN WITH SPECIAL HEALTH NEEDS (Vermont Department of Health)		
Children with Special Health Needs Care Coordinator/Contact: ☐ **Respite (annual allocation): $_____** ☐ Child Development Clinic (Date): ☐ Cleft Palate Clinic ☐ Physiatry Clinic ☐ CF Clinic		
Children's Personal Care Services ☐ New Application ☐ Current Allocation/Level:		
High-Technology Home Care ☐ Level of Service Authorized:		
Pediatric Palliative Care Program (in conjunction with DVHA)		
Other:		

	Previously Received	Currently Receiving
COMMUNITY MENTAL HEALTH AND/OR DEVELOPMENTAL DISABILITY SERVICES SUPPORTS (Department of Mental Health and Department of Disabilities, Aging and Independent Living)		
School Based Clinician/Home-School Coordination		
Individual Therapy		
Family Therapy		
Group Therapy		
Behavioral Services/consultation		
Autism Services		
Psychiatric Services (Medication Management)		
Crisis Services		

COMMUNITY MENTAL HEALTH AND/OR DEVELOPMENTAL DISABILITY SERVICES SUPPORTS (cont'd) (Department of Mental Health and Department of Disabilities, Aging and Independent Living)		
	Previously Received	**Currently Receiving**
Intensive Family Based Services		
Traumatic Brain Injury Supports		
Respite		
Community Supports		
Flexible Family Funding: ☐ **Waiting List** ☐ **Annual Level of Funding:**		
Home Modifications		
Other (please specify):		

Is there a need for assistance/support to access any of the above services? Either services the child is currently receiving or services the child might benefit from access to? If yes, please indicate which service(s)

H. Description of Direct Evaluation

Provide a brief description of your interaction/evaluation of this child for these supports. Please provide as much detail as possible related to your interaction and the child's participation.

I. Signature Page and Consent for Information Sharing

Assessor and Parent Signature

Parent/Guardian:
I acknowledge that the Children's Personal Care Services application—including Integrated Family Services Intake, Functional Ability Screening Tool and Care Plan—was performed with input provided by me and direct interaction with my child.

_____ _____
Parent/Guardian Signature Date

Assessor:
I acknowledge that I completed Children's Personal Care Services application—including Integrated Family Services Intake, Functional Ability Screening Tool and Care Plan, with input from the parent/guardian and direct interaction with the child.

_____ _____
Assessor Signature Date

Consent for Information Sharing—within Agency of Human Services

By signing this form, I authorize and give my permission to allow disclosure:

OF INFORMATION obtained by me in the course of applying for and/or receiving services or benefits through the Agency of Human Services (AHS)

FROM a staff person on an AHS department, division

TO a staff person of another AHS department, division

FOR THE PURPOSES OF:

Determining eligibility for services or benefits
Providing services or benefits to the fullest extent and most efficient manner
Ensuring that services provided by AHS are coordinated and not duplicated
Avoiding repetitive and unnecessary paperwork

You do not have to sign this form. If you chose not to sign, any benefit to which you/your child is entitled will not be affected. However, by not giving authorization to share information, you may not be able to participate in certain services to the fullest extent and as efficiently as possible.

By signing the form, I understand:

1) The reason(s) I am being asked to authorize the release of information
2) That only information that is relevant to my application for or receipt of AHS services or benefits shall be disclosed, and only to the minimum extent necessary to accomplish the purposes identified above.
3) That AHS departments and division may legally share most of the personal information they have about me on a need to know basis. However, state and federal laws do restrict sharing of certain types of information, absent my authorization.
4) That I am authorizing AHS department and divisions to communication to disclose to one another personal information, when relevant, that otherwise could not be shared under state and federal law as referenced above.
5) While AHS takes every precaution to protect my health and other personal information, one it is disclose pursuant to this authorization, it may be subject to re-disclosure.
6) The re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status, without consent, is prohibited by law. By signing this form, I authorize the initial disclosure of such information, if applicable, as well as any subsequent disclosure among AHS departments and divisions.
7) By checking the box below, I signify that I have **not** consented to the re-disclosure of such information:

   ☐ I do not consent to re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status.
8) I may revoke this authorization at any time by contacting: **Children's Personal Care Services** at **800.660.4427,** except to the extent that it has been acted upon.
9) If I do not revoke or update the authorization, it will be in effect as long as I am receiving AHS services or benefits.

10) I will be provided a copy of this information

If you have questions about this form, please contact Children's Personal Care Services by calling 800.660.4427.

Signature of Individual or Parent/Legal Representative **Date**

Relationship to Beneficiary

Signature of Assessor/Individual Explaining Authorization **Date**

Name

Organization

Consent for Information Sharing—between AHS and Designated Agency

By signing this form, I authorize and give my permission to allow disclosure:

OF INFORMATION obtained by me in the course of applying for and/or receiving services or benefits through the Agency of Human Services (AHS) or Designated Agency (DA)

FROM an AHS staff person

TO a staff person of a designated agency

FROM a staff person of a designated agency

TO an AHS staff person

FOR THE PURPOSES OF:

Determining eligibility for services or benefits
Providing services or benefits to the fullest extent and most efficient manner
Ensuring that services provided are coordinated and not duplicated
Avoiding repetitive and unnecessary paperwork

You do not have to sign this form. If you chose not to sign, any benefit to which you/your child is entitled will not be affected. However, by not giving authorization to share information, you may not be able to participate in certain services to the fullest extent and as efficiently as possible.

By signing the form, I understand:

1) The reason(s) I am being asked to authorize the release of information
2) That only information that is relevant to my application for or receipt of AHS or DA services or benefits shall be disclosed, and only to the minimum extent necessary to accomplish the purposes identified above.
3) That AHS and the DA may legally share most of the personal information they have about me on a need to know basis. However, state and federal laws do restrict sharing of certain types of information, absent my authorization.
4) That I am authorizing AHS and the DA to communication to disclose to one another personal information, when relevant, that otherwise could not be shared under state and federal law as referenced above.
5) While AHS and the DA takes every precaution to protect my health and other personal information, one it is disclose pursuant to this authorization, it may be subject to re-disclosure.
6) The re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status, without consent, is prohibited by law. By signing this form, I authorize the initial disclosure of such information, if applicable, as well as any subsequent disclosure among AHS departments and divisions and the DA.
7) By checking the box below, I signify that I have **not** consented to the re-disclosure of such information:

☐ I do not consent to re-disclosure of information concerning alcohol or drug abuse diagnosis, treatment or referral for treatment and HIV status.

8) I may revoke this authorization at any time by contacting: **Children's Personal Care Services** at **800.660.4427,** except to the extent that it has been acted upon.
9) If I do not revoke or update the authorization, it will be in effect as long as I am receiving services or benefits.
10) I will be provided a copy of this information

If you have questions about this form, please contact Children's Personal Care Services by calling 800.660.4427.

_____ _____

Signature of Individual or Parent/Legal Representative **Date**

_____

Relationship to Beneficiary

_____ _____

Signature of Assessor/Individual Explaining Authorization **Date**

_____

Name

Organization _____

Consent for Information Sharing—between AHS and Health Care Providers

I hereby authorize:

☐ All health care providers listed in this document ☐ The following providers:

_____

_____

_____

_____

to disclose to the Vermont Department of Health, Children with Special Health Needs (CSHN) pertinent medical, educations, social or mental health records, X-rays, and/or screening reports **for the purpose of determining medical necessity for Children's Personal Care Services regarding this applicant.**

Eligibility for Children's Personal Care Services is not conditioned upon my authorizing this disclosure. Further, I may revoke this authorization at any time except to the extent that CSHN has already acted in reliance of it. In general, revocation must be submitted in writing and sent to CSHN/CPCS at this address:

Vermont Department of Health/Children with Special Health Needs
280 State Drive
Waterbury, VT 05671-8360
Attn: Children's Personal Care Services

Means of disclosure (check all that apply):

☐ written ☐ electronic
☐ oral ☐ audio tape

Date upon which this authorization will expire:_____/___/_____(mm/dd/yyyy). If no date is noted, expiration is three (3) years from the date it is signed.

_____ _____

Signature of Individual or Parent/Legal Guardian **Date**

_____ _____

Printed Name **Relationship to Beneficiary**

Witness (age 18 or older): _____

Signature and Title

Date: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

_____

Signature of Individual or Parent/Legal Guardian