**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

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: ______________

Identifying Information

Child/Youth: ____________________

DOB: __________ **Age:** __________ **Gender:** __________

MaineCare #: __________ **Social Security #:** __________

Address: ____________________

City: __________ **State:** __________ **Zip:** __________

Own Guardian: ☐ Yes ☐ 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): __________

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: ______________________

Contact List

Mother:

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Father:

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Guardian (if not parent):

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Other Parenting Figure (foster parent, kinship care etc.):

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Extended Family Member(s) or Natural Supports:

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Extended Family Member(s) or Natural Supports:

Name: ____________________
Address: ____________________
Phone : __________ Phone: __________ Email: __________
Release completed: ☐ Yes Release expires: __________

Siblings:

Name	Age	Live with Child:	Release Complete	Release Expires
		☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	
		☐ Y ☐ N	☐ Y ☐ N	

Services

Case Management Agency: ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Primary Care Doctor: ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Other Doctor: ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Therapist: ☐ Occupational ☐ Physical ☐ Speech and Language ☐ Mental Health ☐ Other:
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Therapist: ☐ Occupational ☐ Physical ☐ Speech and Language ☐ Mental Health ☐ Other:
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

School ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Child Care Provider: ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

Other Provider: ______________________
Address: ______________________
Phone: __________ Fax: __________ Email: __________
Release completed: ☐ Yes ☐ No Release expires: __________

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:

	Yes	No
Has there been a recent change in the child's sleep pattern?	☐	☐
Does your child:		
• Sleep through the night?	☐	☐
• Have nightmares?	☐	☐
• Take naps?	☐	☐
Do you have concerns about your child's sleep patterns?	☐	☐

Explain:

Physical Complaints:

Does your child have:	Yes	No
• Frequent headaches?	☐	☐
• Frequent stomach aches?	☐	☐
• Frequent muscle pain?	☐	☐
• Frequent itching?	☐	☐
• Other?	☐	☐

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

Explain:

	Yes	No
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	☐	☐	☐
Verbal	☐	☐	☐
Cognitive	☐	☐	☐
Emotional	☐	☐	☐
Social	☐	☐	☐
Toileting	☐	☐	☐

Other Information: ______________________

What else is important to you about your child's developmental history? ______________________

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 ☐ Preschool ☐ Public Pre-K ☐
Home School ☐ Public School ☐ Private School ☐
Other: ☐ ____________________

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	☐	Moderate	☐	Low	☐
Emotional Reactions:	Strong	☐	Moderate	☐	Minimal	☐
Emotional Recovery Time:	Long	☐	Average	☐	Short	☐

Would you describe your child as?

	Yes	No
Affectionate	☐	☐
Co-operative	☐	☐
Patient	☐	☐

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:

Self-Awareness:			
Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never	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:			
Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never	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:			
Rating Scale: 1- Always; 2- Most of the time; 3- Sometimes; 4-Rarely; 5- Never	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?			

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

Interpersonal:

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

Leisure Time:			
Rating Scale: 1 - Yes; 2 - No	Date	Date	Date
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 ☐, Clubs ☐, Church, ☐ Community Center ☐ Other If yes, describe:			
What else is important to you about your child's leisure time?			

Social Functioning Summary

Areas of Strength:

Areas of Concern:

Behavioral Functioning

Consider the developmental ability of the child when responding.

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

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

Does your child injure him/herself? ☐ Yes ☐ No
If yes, describe how and how often:

Physical Aggression:			
Rating Scale: *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

Functional Life Skills- Activities of Daily Living

Consider the developmental ability of the child when responding.

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

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

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

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

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

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

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

Money:			
Rating Scale: 1- Independent; 2- Minimal Support; 3- Needs Support in Specific Areas; 4- Regular Supervision/Support; 5 – Dependent on Others	Date	Date	Date
• Understand the concept of money?			
• Understand the concept of using a bank?			
• Maintain a bank account?			
If yes, specify type: Checking ☐ Savings ☐ Both ☐			
Money Total			
Does your child need a representative payee? ☐Yes; ☐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?