CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Welcome to Children's Therapy Center Early Intervention!

Attached you will find a description of the eligibility process and the paperwork needed for your child's developmental evaluation. Please let us know if you have any questions or if we can assist you in any way.

During this initial evaluation, we will:

- ask you questions about your child's development, including what your child does well and what you have concerns about
- observe your child playing with different toys/materials
- complete developmental tests and share the results with you
- talk about options for services for your child

This developmental evaluation will take 1 – 1 ½ hours.

What to bring to your appointment:

- Enclosed paperwork, filled out as thoroughly as possible
- Your CHILD's insurance card and/or Provider One card
- Reports from previous tests or evaluations, if available

If you have any questions, please call us at 253-854-5660. Thank you.

Regards,

CTC Early Intervention Program Staff

Note: If you need to reschedule, please call us as soon as possible so that we may offer this appointment to another family.

Children's Therapy Center Early Intervention Eligibility Process

Referral

Your child has been referred for an Early Intervention (EI) evaluation. The referral may come from the family, the child's doctor, childcare provider or another community agency.

⇩

Evaluation

At the evaluation, a team of professionals will evaluate your child in five areas:

- Cognitive: Learning, thinking, playing , problem solving
- Communication: Understanding what others say; expressing thoughts in gestures, sounds, words
- Motor: Coordinating movements; manipulating toys, sitting, crawling, walking
- Social/Emotional: Getting along w/ others, self-soothing and participating in routines
- Adaptive: Calming, feeding, sleeping and dressing

Children over 16 months are screened for signs of Autism.

⇩

Eligibility

At the end of the evaluation, we will discuss your child's eligibility for early intervention services.

- Children are eligible if they show a 25% delay in any area of development.
- Some children are eligible because they have a diagnosis that has a high probability of resulting in a developmental delay.
- If your child is not eligible, we provide suggestions and community referrals.
- If your child is eligible and you choose to enroll in CTC Early Intervention, the next step will be to develop an IFSP.

⇩

Individualized Family Service Plan (IFSP)

- At this visit, which is typically held at your home, we will discuss the concerns and priorities you have for your child. We will develop goals and decide what therapy and/or education services are best for your child.

⇩

Services

Once the IFSP is completed, services for your child can begin.

- Early Intervention is a family-based program, so you will be an active participant in your child's services.
- Services might include physical therapy, speech therapy, feeding therapy, occupational therapy, CHERISH (supporting the social and emotional needs of foster children), and/or early education.
- Therapists and educators provide family members with strategies and activities to do during your child's daily routines (meals, play, dressing, outings, bedtime). They will also share information about child development and support you as your child's primary teacher.
- Each family has a Family Resources Coordinator (FRC) to help families develop the IFSP and to help families connect to community resources they may need.

CTC EI aims to empower families within their community and children within their family.

CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Notice & Consent for Initial Evaluation/Assessment

PURPOSE: To provide prior written notice to the parent(s)/guardian(s) when an initial evaluation/assessment is being proposed and to obtain parental consent to conduct the initial evaluation/assessment being proposed.

CHILD'S NAME	DATE OF BIRTH	FAMILY RESOURCES COORDINATOR

REASON FOR NOTICE

Children's Therapy Center Early Intervention is required to provide you with written prior notice within a reasonable time before conducting evaluation and assessment activities. It is required that you give informed, written consent for these activities through your signature below. The purpose of evaluation and assessment is to obtain information about your child from you and other people you ask to participate; provide your family with additional information about your child's development; identify the unique strengths and needs of your child and the services that may be appropriate to meet those needs; determine whether your child is eligible for Washington State Early Supports for Infants and Toddlers (ESIT) program; and if your child is eligible, with your agreement and participation, develop a written Individualized Family Service Plan (IFSP). This is your statement of that notice.

"Consent" means that: (1) You have been fully informed of all information relevant to the activity(ies) for which consent is sought in your native language (unless clearly not feasible to do so) or mode of communication including sign language, Braille, or oral communication as appropriate; (2) that you understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; (3) the consent describes the activity(ies)and lists the early intervention records (if any) that will be released and to whom they will be released; and (4) the granting of your consent is voluntary and may be revoked in writing at any time. If you revoke consent, it is not retroactive (it does not apply to an action that occurred before the consent was revoked).

ACTION PROPOSED

An evaluation and assessment will be conducted by at least two qualified individuals from different disciplines (or one qualified professional from two disciplines) in accordance with ESIT program policies and procedures. Your participation as a member of the evaluation team is strongly encouraged. You know your child best and can provide important information about your child. The evaluation and assessment is a comprehensive view of how your child is doing in the areas of cognitive, gross motor, fine motor, communication, social-emotional and adaptive development, as well as vision and hearing. The results indicate how your child is doing in all of these areas and whether or not your child is eligible for ESIT services. The results indicate how your child is doing in all of these areas and if your child is eligible for ESIT services.

DESCRIPTION

The evaluation proposed will include multiple procedures, including administration of an evaluation instrument, taking the child's history, interviewing the parent(s), gathering information from other family members, caregivers, medical or other professionals and reviewing medical, educational or other records. The proposed assessment procedures will determine your child's unique strengths and needs and appropriate early intervention services. Assessment will include: a review of evaluation results; personal observations of the child, identification of the child's needs in each developmental area through the use of formal and informal assessment procedures. Children's Therapy Center Early Intervention providers will talk with you about the methods they will use for this evaluation and assessment. The evaluation and assessment will be provided at no cost to you. The results are kept in your child's early intervention record. No information about the evaluation/assessment will be shared with anyone or any agency outside of the ESIT program unless you provide written consent to do so. The IFSP team will determine whether or not your child is eligible and will provide prior written notice, including your right to dispute the eligibility determination.

TIMELINES

Date your child was referred to the ESIT program for evaluation/assessment: _____

The multidisciplinary team will complete an evaluation/assessment and if your child is eligible, and you agree, the development of an Individualized Family Service Plan (IFSP) must be completed within 45 calendar days from the date your child was referred. If your family needs additional time beyond the 45 days, it is important that you tell your Family Resources Coordinator. The IFSP is a written plan developed in partnership with your family and professionals to meet the ongoing needs of your child and family. It can be changed at any time. The IFSP is written only if your child is eligible for services.

The Department of Early Learning, Washington Early Support for Infants and Toddlers (ESIT) Program

Attachment: ESIT Program Part C Procedural Safeguards (Parent Rights)
Note: *Parents/Guardians are to receive a copy of this form and a signed copy is to be included in the child's early intervention record.*

CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

EARLY INTERVENTION QUESTIONNAIRE

The following information will help us to serve your child and family through our program. All information is voluntary and confidential.

Child's Name: _____

Information About Your Family

Please list the adults who live in your home:

Name	Relationship to Child	Occupation/Job	Language(s) Spoken

Please list the children who live in your home:

Name	Gender (M/F)	Birthdate	General Health

Who are the people who take care of your child?

Name	Relationship to Family/Child

Natural Environments Information

Learning occurs best when it takes place in your child's natural environment including daily routines. To help us learn about your child, please consider the following daily routines/community activities in which young children often participate.

Daily Routines: Dressing & undressing, toileting/bathing, mealtimes, bed-time/naptime, playing with siblings, friends, and adults

Community Activities: Grocery store/shopping, going to a restaurant, the library, relative/friend's house, parks/playgrounds/play structures, church nursery, medical appointments, daycare center, Mom's groups, parent groups, play groups, etc.

What activities do you and your child enjoy? _____

_____

_____

Are any activities challenging for you or your child? Please describe: _____

_____

_____

CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Phone: 253-854-5660
Fax: 253-854-7025
www.ctckids.org

Kent
10811 SE Kent-Kangley Rd.
Kent WA 98030

Burien
127 SW 156th St.
Burien, WA 98166

Tacoma
8717 S Hosmer St.
Tacoma, WA 98444

RELEASE OF INFORMATION

I, **(Parent/Guardian)**_____, hereby grant consent for Children's Therapy Center to give and/or receive information pertaining to the Physical/Occupational/Communication/Oral Motor Therapy, Prosthetic/Orthotic programs and/or Education programs for (**Child's Name**) _____ **(other names known by)** _____ (**Child's Date of Birth)**_____ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

Please list names of people who help you with your child, including primary physician, public health nurse, therapists, specialists, day care staff, and other agencies:

Contact Person's Name	Agency/Clinic Name and Address	Phone #
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
Caseworker:		
Physical/Occupational/Speech Therapist:		
Other:		

Rights: I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for the organization to share information regarding the patient on my behalf. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____ _____

Signature of Parent or Legal Guardian **Relationship to Child** **Date**

Expiration: This release will be valid for the patient's duration of participation in our programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.

As a nonprofit agency, we receive funding from United Way. We are requested by United Way to collect demographic information for participants in our program. This survey does not include your name so that your identity is totally confidential. Please take a few moments to complete this form. Thank you!

Client Demographic Form July 2016 - June 2017

Instructions: *Please write clearly. Enter numbers or mark **X** in the appropriate boxes.*

1. Geographic Region:
We live in
Zip Code: 9 8 ☐ ☐ ☐

We live OUTSIDE the city limits:
☐ YES ☐ NO

2. Household Composition
Please check one:
- ☐ Two parent household
- ☐ Single parent (male)
- ☐ Single parent (female)
- ☐ Other related household

3. Total Gross Household Income
Please check one **based on the chart below**:
- ☐ Under 30% of Median Income (A)
- ☐ Under 50% of Median Income (B)
- ☐ Under 80% of Median Income (C)
- ☐ Equal or Above 80% of Median Income (D)

4. Are you currently homeless? (check one)
☐ YES ☐ NO

5. Child's Age: ☐☐ **Years** ☐☐ **Months**

6. Child's Gender: (check one)
☐ Female ☐ Male

7. Ethnicity:
Child is Spanish / Hispanic / Latino
☐ YES ☐ NO

8. Child's Race: (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian, Asian American
- ☐ Black, African American, Other African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ Other

9. Limited English Proficiency
Are you (parent/adult) limited in your ability to communicate in English? (check one)
☐ YES ☐ NO

REVISED 04/17

King County - HUD Income Guidelines - 2016

Instructions: Under FAMILY SIZE, choose the row for the number of people in your household. Select the income range in that row for your ANNUAL GROSS INCOME for last year. The letter above that column will be your income category.

	Percent of Median Income			
	30% HUD PMSA	50% HUD PMSA	80% HUD PMSA	Over 80% HUD PMSA
FAMILY SIZE	Very Low	Low	Moderate	Above Moderate
↓↓↓	Category A	Category B	Category C	Category D
1 Person	Up to $ 19,000	$ 19,001 to $ 61,650	$ 61,651 to $ 48,550	$ 48,551 or more
2 Persons	Up to $ 21,700	$ 21,701 to $ 36,150	$ 36,151 to $ 55,450	$ 55,451 or more
3 Persons	Up to $ 24,400	$ 24,401 to $ 40,650	$ 40,651 to $ 62,400	$ 62,401 or more
4 Persons	Up to $ 27,100	$ 27,101 to $ 45,150	$ 45,151 to $ 69,300	$ 69,301 or more
5 Persons	Up to $ 29,300	$ 29,301 to $ 48,800	$ 48,801 to $ 74,850	$ 74,851 or more
6 Persons	Up to $ 32,580	$ 32,581 to $ 52,400	$ 52,401 to $ 80,400	$ 80,401 or more
7 Persons	Up to $ 36,730	$ 36,731 to $ 56,000	$ 56,001 to $ 85,950	$ 85,951 or more
8 Persons	Up to $ 40,890	$ 40,891 to $ 59,600	$ 59,601 to $ 91,500	$ 91,501 or more

FY 2016, Median 4 Person Family income = $90,300
HUD (U.S. Department of Housing and Urban Development) rev 8/2016
PMSA (Primary Metropolitan Statistical Areas)

United Way
King and Pierce County

Thank you for your reply.

Your information will be kept completely confidential.

Public Health Seattle-King County
Children with Special Health Care Needs Intake Form

CHILD'S NAME: LAST, FIRST MI ***(PLEASE PRINT CLEARLY)***	**CHILD'S DATE OF BIRTH: MM/DD/YYYY:**	**GENDER (please circle) M or F**

CITY OF RESIDENCE:	**YOUR ZIP CODE**

GROSS MONTHLY INCOME: please check which level or provide the dollar amount and number of people in your home:
Our income is less than 210% of the Federal Poverty Level _____
Our income is more than 210% of the Federal Poverty Level _____
OR
Number of people living in your home: _____
Average **monthly** income for this household: _____

Eligibility for state Apple Health plans is based on income and the number of family members in the home.

RACE: Please check one:
- ☐ Asian
- ☐ Black/African Am
- ☐ Native American
- ☐ Alaska Native
- ☐ Hispanic
- ☐ White
- ☐ Multi-racial
- ☐ decline

COUNTY OF RESIDENCE:
- ☐ **KING**,
- ☐ **SNOHOMISH,**
  OR
- ☐ **PIERCE**

INSURANCE COVERAGE: please check those that apply

☐ **Apple Health (aka Medicaid/Provider One)**
(If your child has a Provider One number, please provide it or a copy of your Provider One card)
**** PROVIDER ONE NUMBER: _____WA (**REQUIRED INFORMATION)**

☐ **Private insurance through parent(s) employer, not through state.**

☐ **Tri-Care (CHAMPUS – military)** ☐ **None**

DIAGNOSIS I	**ICD-10 CODE**	**DIAGNOSIS II**	**ICD-10 CODE**

COMMUNITY AGENCIES MY CHILD RECEIVES SERVICES THROUGH:
- ☐ **WIC**
- ☐ **SOCIAL SECURITY INCOME/DISABILITY**
- ☐ **DIVISION OF DEVELOPMENTAL DISABILITIES**
- ☐ **CHILDREN'S HOSPITAL (Includes Mary Bridge)**
- ☐ **FOSTER CARE**
- ☐ **PUBLIC SCHOOLS**
- ☐ **BIRTH TO THREE PROGRAM**

WHICH BIRTH TO THREE PROGRAM IS PROVIDING SERVICES:
- ☐ **Birth to Three Center Federal Way**
- ☐ **Boyer Children's Clinic**
- ☑ **Children's Therapy Center (Kent)**
- ☐ **Kindering Center**
- ☐ **Mary Bridge Neuro-developmental Program**
- ☐ **Valley Medical Center - CTU**

Children with Special Health Care Needs program (CSHCN) is a state and federally funded Title V program offered through Public Health, Seattle-King County. The CSHCN program provides the above information to the state for statistical purposes and coordination of care through the Health Care Authority
.

☐ **I authorize this information be provided to Public Health Seattle-King County, Children with Special Health Care Needs program**

_____ _____ _____/____/_____
Signature of parent/guardian **Relationship to child** **Date**

Children with Special Health Care Needs
Public Health, Seattle-King County
401 Fifth Ave; Suite 1000
Seattle, WA 98104-1818
Phone: 206-296-4610 Fax: 206-296-4679

Public Health
Seattle & King County