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.

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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.

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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.

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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.

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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.

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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.

Children with Special Health Care Needs
CHILD HEALTH INTAKE FORM

☐ Case Management ☐ CSHCN Eligible				☐ New ☐ Renewal
CHILD'S NAME (LAST, FIRST, MI)	2. DOB	3. SSN	4. SEX	5. RACE/ETHNIC PREFERENCE
6. FATHER/GUARDIAN/FOSTER PARENT NAME	7. DOB	8. SSN	9. FAMILY SIZE	LANGUAGE 10. 11.12.13.
14. MOTHER/GUARDIAN/FOSTER PARENT NAME	15. DOB	16. SSN	16A. MOM'S EDUCATION LEVEL	17. REFERRED BY
19. ADDRESS CITY STATE ZIP	20. PHONE (Home)	21.PHONE (Work)	22. PHONE (Message)	18. INCOME: UNDER / OVER 200% FPL

24. OTHER DEPENDENTS IN HOUSEHOLD	25. RELATIONSHIP	26. DOB	27. PRIMARY PHYSICIAN/ADDRESS/PHONE
			28. DIAGNOSIS/MEDICAL PROBLEMS/ICD-9
			29. ICD-9-CODE(S)

30. NOTES / COMMENTS	30(A).	31. CHIF DATE
	33. MEDICAL HISTORY	

32. REASON FOR REFERRAL	35. HEALTH/MEDICAL INSURANCE
	☐ INSURARANCE Name: _____ Group #: _____
	☐ INSURARANCE Name: _____ Group #: _____
34. OTHER HEALTH CARE SPECIALISTS/PROVIDERS	☐ CHAMPUS/TRICARE: _____ _____ Group #: _____
	☐ MEDICAL COUPONS: _____ PIC # / CASE #: _____ _____ _____
	☐ OTHER: _____ _ _____

36. AGENCY INVOLVEMENT: (Please check all that apply)

☐ WIC ☐ SSI ☐ SSS ☐ DDD ☐ FOSTER CARE ☐ SCHOOL/IEP/IFSP_____ ☐ GS-CTU ☐ MB-NDP

☒ CHILDREN'S THERAPY CENTER-TACOMA ☐ _____ ☐ _____ ☐ BIRTH TO THREE DEV CTR FW

AGENCY SUBMITTING THIS CHIF: CHILDREN'S THERAPY CENTER – TACOMA

DO NOT WRITE IN SHADED AREAS

Submitting Agency: Please return this completed form to: Children w/Special Health Care Needs Program in Client's County