

**FAMILY SUPPORT SERVICES PROGRAM MOST IN NEED ASSESSMENT (FSSP MIN)**

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| --- |
| **CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **AGE: \_\_\_\_\_\_\_\_** |
| **FORM COMPLETED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****COUNTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

**INSTRUCTIONS:** In each category below, please check the best area that you feel best describes your family member’s developmental disability or delay.

***Please check ONLY ONE BOX in the Needs area AND in the Resources area for each category.***

|  |
| --- |
| **1. MOBILITY** |

**Needs** C*onsider balance, coordination, and amount of assistance needed for mobility and transfers; compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | Person can walk independently; mobility is not limited, person has full use of hands and feet. |
|  | Person can walk with some assistance, has use of hands and feet. |
|  | Limited use of hands and feet; person is unable to walk; person can partially assist with transfers; weight/size is not a problem. |
|  | Person is unable to walk or move around alone; unable to assist with transfers and/or their weight/size makes transfers difficult. |

**Resources** *Access to adaptive equipment, therapies, support from other people, agencies, and funding sources*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **2. HEARING** |

**Needs** *Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | There are no hearing concerns.  |
|  | The person has mild hearing loss. |
|  | The person has moderate hearing loss. |
|  | The person has severe to profound hearing loss.  |

**Resources** *Availability of hearing devices, specialists, and funding sources*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **3. VISION** |

**Needs** *Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | There are no vision concerns. |
|  | Vision is correctable with glasses or contacts. |
|  | There is a reduced ability to see, even with glasses or contacts. |
|  | There is little or no functional sight. |

**Resources** *Availability of corrective lenses or assistive technology, specialists, and funding sources*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **4. MEDICAL/NURSING CARE** |

**Needs** *Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | Person does not require any more medical care than routine medical appointments. |
|  | Person requires more medical care than routine medical visits. |
|  | Person requires medical care for a frequent and acute illness or medical condition  |
|  | Person has medical needs that significantly impact their ability to participate in home, school, and community activities.  |

**Resources** *Adequate medical coverage, access to healthcare, etc.*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **5. TRANSPORTATION** |

**Needs** *Is the vehicle adequately equipped for your child? Is transportation difficult? Do you spend excessive amounts of time transporting for medical appointments?*

|  |  |
| --- | --- |
|  | Person/family has a typical transportation situation. |
|  | Person/family’s participation in home, school, or community activities is interrupted by access to transportation at least once a week.  |
|  | Person/family’s participation in home, school, or community activities is interrupted by access to transportation more than once a week.  |
|  | Person/family has no reliable access to transportation.  |

**Resources** *Availability or presences of ramps, vehicle adaptations, other persons/agency support)*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **6. SELF-CARE SKILLS** |

**Needs** *Feeding, bathing, dressing, toileting Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | Person is able to consistently perform self-care tasks. |
|  | Person requires verbal reminders to start/complete some tasks. |
|  | Person requires hands-on assistance to complete most tasks. |
|  | Person requires total care not consistent with others their age. |

**Resources** *Availability of support from family, neighbors, friends, agencies*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **7. SUPERVISION** |

**Needs** *Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | Supervision typical for that age. |
|  | Person needs occasional supervision. |
|  | Person requires frequent supervision. |
|  | Person requires constant supervision (can never be unsupervised) |

**Resources** *Shared caregiving in the home, support by extended family, friends, neighbors, agencies*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

|  |
| --- |
| **8. BEHAVIOR** |

**Needs** *Inappropriate behaviors against self, others and/or property, running, wandering, spontaneous crying/screaming; compare to typical development consistent, with age*

|  |  |
| --- | --- |
|  | There are no behavioral concerns.  |
|  | There are mild behavioral concerns. May require verbal reminders, redirection or supervision but usually do not result in injury to self, others or property.  |
|  | There are moderate behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least weekly.  |
|  | There are extreme behavioral concerns. Exhibits inappropriate behaviors that put self or others at risk; requires frequent interventions at least daily.  |

**Resources** *Breaks from caregiving, therapies, support from others/agencies*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

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| --- |
| **9. SLEEP** |

**Needs** *Compare to age-appropriate sleep patterns*

|  |  |
| --- | --- |
|  | There are no sleep problems. |
|  | There are mild disturbances in sleep patterns that occur approximately once a week. |
|  | There are moderate disturbances in sleep patterns that occur approximately two to five times a week.  |
|  | There are high disturbances in sleep patterns that require many interventions throughout the night.  |

**Resources** *Shared care-giving, breaks from constant supervision, sleep aids/medications, modified sleeping environment*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

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| **10. COMMUNICATION** |

**Needs** *Compare to typical development, consistent with age*

|  |  |
| --- | --- |
|  | There are no communication concerns. |
|  | There are mild communication concerns. Can consistently meet needs & wants through limited verbal skills with familiar and unfamiliar people.  |
|  | There are moderate communications concerns. Uses alternative means to communicate such as pointing, PECS, or device; understood only by familiar people. |
|  | There are extreme communication concerns. Limited or inconsistent ways of communicating with others.  |

**Resources** *Availability of communication devices, sign language, caregivers understanding of personal language/gestures/expressions*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

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| --- |
| **11. ACCESS TO SUPPORT NETWORKS** |

**Needs** *Compare to typical family routines, activities/leisure and community involvement*

|  |  |
| --- | --- |
|  | These are not affected by having a person with DD in the home. |
|  | These are mildly affected by having a person with DD in the home. |
|  | These are moderately affected by having a person with DD in the home. |
|  |

|  |
| --- |
| These are extremely affected by having a person with DD in the home.  |

 |

**Resources** *Shared care-giving, support from extended family/friends, church, community organizations, agencies*

|  |  |
| --- | --- |
|  | **No Needs** in this area. |
|  | Needs are **completely met.** |
|  | Needs are **mostly met.** |
|  | Needs are **occasionally met.** |
|  | Needs are **not met at all.** |

**Comments**

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| --- |
| **12. FAMILY COMPOSITION & STABILITY** |

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| --- |
| **Please mark ONE box that best represents your family/living situation:****0 = no problem or does not apply 1 = mild problems 2 = moderate problems 3 = severe problems** |
| **0** | **1** | **2** | **3** |  |
|  |  |  |  | 1. Relationships are strained within the family.
 |
|  |  |  |  | 1. There are other children or adults with disabilities/delays/illnesses in the home.
 |
|  |  |  |  | 1. Siblings show signs of stress due to a family member with a developmental disability living in the home.
 |
|  |  |  |  | 1. Our family has responsibility for other extended family members.
 |
|  |  |  |  | 1. There has been a recent (within the last year) divorce, separation, death or addition of a family member.
 |
|  |  |  |  | 1. Our family’s activities center around the needs of the family member with a developmental disability.
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|  |  |  |  | 1. Caregiver spends excessive time away from job to meet the needs of family member with a developmental disability.
 |
|  |  |  |  | 1. Caregiver has had to quit their job or is unable to work due to the needs of the family member with a developmental disability.
 |
|  |  |  |  | 1. Caregiver spends excessive time coordinating various needs for the family member with a developmental disability.
 |
|  |  |  |  | 1. There is stress on the caregiver.
 |
|  |  |  |  | 1. There are additional difficulties due to the aging/health of caregiver.
 |
|  |  |  |  | 1. Caregiver experiences additional difficulties due to family member with a developmental disability being home all day (no school/respite).
 |

**Comments**

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| **13. ADDITIONAL RESOURCES** |

**Please CIRCLE the resources any member of your household currently receives:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHP+**  | **Commodities** | **HCA** | **HCBS** | **Early Intervention** | **LEAP** |
| **Medicaid** | **Quest Card** | **RCCO** | **SNAP** | **Section 8** | **SSI** |
| **TANF** | **WIC** | **Other** |  |  |  |

[ ]  ***Check here if you would like an FSSP Navigator to contact you to discuss any of your needs or resources***

**I verify that the information stated above is true to the best of my knowledge**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Signature) (Date)

**Please return all COMPLETED pages**

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