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

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 *Consider 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

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

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

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

12. FAMILY COMPOSITION & STABILITY

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	
				a) Relationships are strained within the family.
				b) There are other children or adults with disabilities/delays/illnesses in the home.
				c) Siblings show signs of stress due to a family member with a developmental disability living in the home.
				d) Our family has responsibility for other extended family members.
				e) There has been a recent (within the last year) divorce, separation, death or addition of a family member.
				f) Our family's activities center around the needs of the family member with a developmental disability.
				g) Caregiver spends excessive time away from job to meet the needs of family member with a developmental disability.
				h) Caregiver has had to quit their job or is unable to work due to the needs of the family member with a developmental disability.
				i) Caregiver spends excessive time coordinating various needs for the family member with a developmental disability.
				j) There is stress on the caregiver.
				k) There are additional difficulties due to the aging/health of caregiver.
				l) Caregiver experiences additional difficulties due to family member with a developmental disability being home all day (no school/respite).

Comments

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

Mail: Imagine! 1400 Dixon Ave Lafayette, CO 80026 Attn: FSSP
Fax: 303-665-2648 Attn: FSSP Email: FSSP@imaginecolorado.org