Dawson Education Service Cooperative
Early Childhood Special Education Department
711 Clinton Street, Suite 201
Arkadelphia, AR 71923
Office (870) 246-7928 Fax (870) 246-3130

Screening Consent Form

Child's Name: (Full Legal Name) ______________________________
First Middle Last (Nickname)

Child's Social Security Number (REQUIRED): ______-______-______ **School District** ______________

Does your child receive Medicaid/ARKids? Yes ☐ No ☐ If yes, Medicaid Number ______________

Date of Birth ______________ Age ______________ Sex: Male ☐ Female ☐

Race: (check all that apply): African American (Black) ☐ White ☐ Asian ☐ Hispanic ☐

American Indian/Native American ☐ Native Hawaiian/Pacific Islander ☐

Parent or Legal Guardian Name: ______________________________
First Last

Address: ______________ City: ______________ State: ______ Zip ______

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Day Time Phone # ______________ e-mail address: ______________

Child's Primary Care Physician: ______________ Clinic ______________ Phone ______________

Child attends (please circle one): Day Care / Head Start / Preschool / Mother's Day Out / Home Based

Center Information: ______________________________
Name Address City Zip Phone

Name of Classroom Teacher ______________________________

Has your child had any previous evaluations: Yes ☐ No ☐ Has your child received therapy: Yes ☐ No ☐

If yes to either of the above questions, please explain: ______________________________

Are their any behavioral issues? If so, please explain: ______________________________

Will an interpreter be needed? Yes ☐ No ☐ Language ______________ or Hearing impaired: Yes ☐ No ☐
(specify lang.)

I give permission to have my child screened by Dawson Education Service Cooperative Special Services Program. The screening may include one or more of the following areas: speech, development, motor, vision and/or hearing. If you have any questions you may call 870-246-7928

Parent Signature for consent to screen: ______________________________ Date: ______________

For office use only: RCVD by ______________ on ____/____/____

Revised August 2015

Parent/Teacher Report and Scoring Form—Self-help and Social-Emotional Scales

A. Child's Name ____________________
Parent(s)/Caregiver(s) ____________________

	Year	Month	Day
Date of Screening	____	____	____
Birth Date	____	____	____
Age	____	____	____

School/Program ____________________
Teacher ____________________
Examiner ____________________

Directions: Read each item and circle the response or description that best reflects the child's skill level

SELF-HELP SKILLS

A. Eating Skills

1. Does ______ use a spoon?
If yes, does ______ place the spoon in his/her mouth without turning the spoon upside down, with little or no spilling of food?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

2. Does ______ use the side of the fork for cutting soft food, such as a piece of baked potato or a piece of cake?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

3. Does ______ hold a fork in his/her fingers, not in his/her fist?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for A. Eating Skills ____ /3

B. Dressing Skills

4. Does ______ put on his/her shoes?
Criteria: Buckling, tying, or Velcro® fastening is not required for credit.

No = 0	Yes (sometimes on wrong feet) = 1	Yes (each shoe on correct foot 90% of the time) = 2	___/2

5. Does ______ dress himself/herself unsupervised?

Rarely/No = 0	Sometimes = 0	Most of the time, except for help with difficult fasteners = 1	
Yes (completely dresses himself/herself, putting all clothes on correctly and fastening all fasteners) = 2	Yes (completely dresses himself/herself, including tying shoelaces and fastening all fasteners) = 3		___/3

6. Does ______ put on his/her socks?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for B. Dressing Skills ____ /6

C. Toileting Skills

7. Does ______ get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

8. Does ______ have bowel movements ("poop") in the toilet or potty (no more than one accident a week)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

9. Does ______ urinate ("pee") in the toilet or potty (no more than one accident a week)?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

10. Does ______ attempt to wipe himself/herself after toileting?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	

OR (Answer only the more appropriate of these two questions.)

Does ______ wipe himself/herself independently after toileting?

Rarely/No = 0	Sometimes = 0	Most of the time = 2	___/2

11. Does ______ take care of his/her toileting needs?

Rarely/No = 0	Sometimes = 0	Yes (flushing the toilet most of the time after using it) = 1	Yes (flushing the toilet and washing and drying his/her hands most of the time) = 2	___/2

12. Does ______ go to the bathroom on his/her own without being asked or reminded?

Rarely/No = 0	Sometimes = 0	Most of the time = 1	___/1

Total for C. Toileting Skills ____ /8

TOTAL FOR SELF-HELP ____ /17
(A. Eating Skills, B. Dressing Skills, C. Toileting Skills)

Self-help and Social-Emotional Scales

SOCIAL AND EMOTIONAL SKILLS

		Item				Score
D.		**Relationships with Adults**				
	13.	Does ______ respond with feelings of pride and enthusiasm when he/she earns positive feedback?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	14.	Does ______ look forward to sharing his/her feelings with you when he/she is happy?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	15.	Does ______ enjoy sharing information with you about himself/herself, such as things he/she likes, names of his/her family members or pets, or what he/she did over the weekend?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	16.	Does ______ share his/her thoughts and ideas with you?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
		Total for D. Relationships with Adults				**___ / 4**
E.		**Play and Relationships with Peers**				
	17.	Does ______ have several friends but one who is a special or best friend?	No = 0		Yes = 1	___ / 1
	18.	Does ______ have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?	No = 0		Yes = 1	___ / 1
	19.	Does ______ play cooperatively in a large-group game, such as duck-duck-goose, tag, or kickball?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	20.	Does ______ give verbal directions or incorporate verbal directions into play activities?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
		Total for E. Play and Relationships with Peers				**___ / 4**

		Item				Score
F.		**Motivation and Self-Confidence**				
	21.	Does ______ maintain interest when engaged in a small-group activity or project?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	22.	Does ______ show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	23.	Does ______ approach new tasks with confidence and a "can-do" attitude?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	24.	Does ______ remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
		Total for F. Motivation and Self-Confidence				**___ / 4**
G.		**Prosocial Skills and Behaviors**				
	25.	If supervised by an adult, does ______ take turns without undue objection?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	26.	Does ______ understand or accept the need to share and take turns, perhaps willingly taking turns even if he/she isn't asked to?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	27.	Does ______ ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as going to the bathroom or leaving the classroom?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
	28.	Does ______ react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?	Rarely/No = 0	Sometimes = 0	Most of the time = 1	___ / 1
		Total for G. Prosocial Skills and Behaviors				**___ / 4**

TOTAL FOR SOCIAL-EMOTIONAL
(D. Relationships with Adults, E. Play and Relationships with Peers, F. Motivation and Self-Confidence, and G. Prosocial Skills and Behaviors) ___ / 16

Confidential Social History

CHILD AND FAMILY HISTORY:

Child's Name: ______________________

Nickname (if used): ______________________

Child's DOB: ______________________

(Month) (Day) (Year)

Child's Social Security #: ______________________

Medicaid Eligibility:

☐ Yes Medicaid #: ______________________

☐ No My child is not Medicaid eligible

Child's Mailing Address

____

City: __________ State: ____ Zip: ________

Child's Physical Address (if P.O. Box):

____

City: __________ State: ____ Zip: ________

School District Child Resides: ______________________

Father's Name: ______________________ Age: ____

Home Phone #: ______________________

Cell Phone #: ______________________

Work Phone #: ______________________

E-mail address: ______________________

Occupation: ______________________

Mother's Name: ______________________ Age: ____

Home Phone #: ______________________

Cell Phone #: ______________________

Work Phone #: ______________________

E-mail address: ______________________

Occupation: ______________________

Child's Siblings:

Name	Age	Sex

If child is in foster care, please list:

DHS Caseworker: ______________________

Caseworker's Phone #: ______________________

How long has child been in foster care?

____

Please describe any extenuating/ unusual traumatic situations (i.e., divorce, neglect, abuse):

CHILD'S PHYSICAL/BIRTH HISTORY:

Was child born at full-term? ☐ Yes ☐ No

If no, how early? ______________________

Child's Birth Weight: ____ lbs. ____ ozs.

Child's Health at Birth: ______________________

Did child's mother have any problem? If yes, please describe:

☐ Yes ☐ No During Pregnancy: ______________________

☐ Yes ☐ No During Delivery: ______________________

EARLY LIFE: Please describe child as an infant (i.e., colicky, fussy, easy to soothe, adaptable, etc.)

CHILD'S MEDICAL HISTORY

Child's Primary Care Physician: ______________________ Phone #: __________

Clinic: ______________________ City: __________

Child has been diagnosed and/ or treated for:

☐ ADD/ADHD ☐ Diabetes ☐ Seizures ☐ Cleft palate

☐ Infections ☐ Ear Infections/PE Tubes ☐ Operations ☐ Sickle Cell

☐ Asthma ☐ Allergies ☐ Other: __________

Please list any medications child is taking: ______________________

CHILD'S NAME: ______________________ **DOB:** __________

Please indicate any of the following with whom you have had contact concerning your child:

	NAME	PHONE #	CITY
☐ Pediatrician			
☐ Primary Care Physician			
☐ ENT Specialist			
☐ Ophthalmologist			
☐ Psychiatrist			
☐ Audiologist			
☐ SLP/ OT / PT			
☐ Others			

CHILD'S DEVELOPMENTAL HISTORY:

Does child say words? ☐ Yes ☐ No

Does child use: ☐ single words ☐ phrases ☐ sentences

Can you understand child's speech? ☐ Yes ☐ No ☐ Sometimes

Does child get frustrated when not easily understood? ☐ Yes ☐ No ☐ Sometimes

CHILD'S SCHOOL HISTORY

Is child enrolled in preschool or daycare center? ☐ Yes ☐ No

If yes, where is your child currently attending? ______________________ City: __________

Center Director's Name: ______________________ Phone: __________

Name of child's preschool teacher(s): (1) ______________ (2) ______________

Please indicate days of week and times your child attends preschool / daycare:

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. Times: _______ am / pm to _______ am / pm

SOCIAL / EMOTIONAL DEVELOPMENT:

Which of the following describes child:

☐ Adjusts with ease to new situations. ☐ Takes time to adjust to new situations.

☐ Has great difficulty with adjustments. ☐ Has never had to adjust to new situations.

If child demonstrates difficulty with adjusting to new situations, please describe behaviors:

Describe child's personality (i.e. affectionate, shy, noisy, fearful, activity level, etc.):

SOCIAL HISTORY COMPLETED BY: ______________________ **DATE:** __________

FOR OFFICE USE ONLY

Additional comments:

☐ All questions and boxes were marked by reporter and / or reviewed by ______________________

ADE SPED
PILOT FORM
JULY 2016

Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: ______________________________ **ID:** ____________ **Date of Birth:** ____________
Age: ________ **Grade:** ________ **Local Education Agency:** ______________________________
Medicaid Number: ____________________

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and/or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may include: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this form.

____ ______________________
Parent or Guardian Signature Date

Is your child covered by private insurance? ☐ No ☐ Yes (If yes, please complete Third Party Liability Section)

ADE SPED
PILOT FORM
JULY 2016

Parental Consent to Release Personally Identifiable Information
Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Name: ______________________________ **ID:** ____________ **Date of Birth:** ____________
Age: ________ **Grade:** ________ **Local Education Agency:** ______________________________
Medicaid Number: ____________________

Information Related to Billing Third Party Insurance:
Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

☐ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school

☐ I give my permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:

Insurance Company: ______________________________

Address: ______________________________

Phone: ______________________________

Name of Policy Holder: ______________________________

Policy Holder Date of Birth: ____________________ Social Security Number: ____________________

Policy Number: ____________________ Group Number: ____________________

______________________________ ______________________________
Parent or Guardian Signature Date