Reset Form

FIRST STEPS ENROLLMENT

State Form 54645 (6-11)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
BUREAU OF CHILD DEVELOPMENT SERVICES
FIRST STEPS EARLY INTERVENTION SYSTEM

First Steps

Part I – Enrollment Application

County of residence of participant	Date of enrollment *(month, day, year)*	First Steps SPOE identification number	
Has this child ever been referred or enrolled in First Steps before? ☐ Yes ☐ No	Previous identification number	Type of referral ☐ New referral ☐ Re-referral	Date of referral *(month, day, year)*

If you are not currently enrolled in the following programs and the family falls within eligible poverty guidelines, please complete the appropriate application and indicate the date of application.

Maternal and Child Health (MCH)	Are you enrolled in MCH? ☐ Yes ☐ No	Identification number	Date of application *(month, day, year)*
	Status ☐ New Enrollment ☐ Reapplication ☐ Pending ☐ Current ☐ Not Applicable		
Children's Special Health Care Services (CSHCS)	Are you enrolled in CSHCS? ☐ Yes ☐ No	Identification number	Date of application *(month, day, year)*
	Status ☐ New Enrollment ☐ Reapplication ☐ Pending ☐ Current ☐ Not Applicable		
Hoosier Healthwise	Are you enrolled in Hoosier Healthwise? ☐ Yes ☐ No	Identification number	Date of application *(month, day, year)*
	Status ☐ New Enrollment ☐ Reapplication ☐ Pending ☐ Current ☐ Not Applicable		

Section A – Participant Information

Last name	First name	Middle initial	Date of birth *(month, day, year)*	Also known as (AKA)
Address *(number and street, apartment number, PO Box number, city, state, and ZIP code)*				
Telephone number ( )	Mother's maiden name	Language spoken ☐ English ☐ Spanish ☐ Other _____		

Section B – Parent / Legal Guardian / Surrogate Parent Information

Name of Parent / Legal Guardian / Surrogate Parent 1		
Address *(number and street, city, state, and ZIP code)*		
Home telephone number ( )	Other telephone number ( )	E-mail address
Name of Parent / Legal Guardian / Surrogate Parent 2		
Address *(number and street, city, state, and ZIP code)*		
Home telephone number ( )	Other telephone number ( )	E-mail address

Name of coordinator / interviewer	
Address *(number and street, city, state, and ZIP code)*	
Telephone number ( )	Fax number ( )

Name of participant

Section C – List all persons (including participant) who live in your household and provide the requested information for each individual.									
Name	**Relationship**	**Date of Birth** ***(month, day, year)***	**Marital Status**	**Gender**	**Race / Ethnicity**	**Migrant / Homeless**	**Education Level**	**Social Security Number**	**PMP** ***(yes/no)***

Section D – Income Verification – How is you family supported? ***Please complete all that apply.***
If unemployed and no income listed below, please attach a statement signed by the family and/ or witness to indicate how the family is supported financially.
Name of employer 1
Name of employer 2
Name of employer 3

Please note the amount and frequency of pay for each person.	**1**	**2**	**3**	**Monthly Gross Income Total**
Name of Person Receiving Income				
Temporary Assistance for Needy Families (TANF)				
Wages / Fees / Commissions / Tips / Sick Benefits				
Social Security / SSI				
Dividends / Interest on Savings				
Unemployment Compensation / Strike Benefits				
Alimony / Child Support				
Any other payments / support / income				
Regular Contributions from persons not living in the household				
Hours worked per week:				**Total household gross income**

Is this month's income the same as the previous three months? ☐ Yes ☐ No	Date income verification sent to employer *(month, day, year)*	
Are you currently paying child care to maintain employment? ☐ Yes ☐ No	Is participant blind / disabled? ☐ Yes ☐ No	Is participant receiving SSI? ☐ Yes ☐ No
Do you pay for the care of an incapacitated adult? ☐ Yes ☐ No	Does anyone living in the household pay support payments? ☐ Yes ☐ No	

Confirmation of Information	
Signature of First Steps intake / service coordinator	Date *(month, day, year)*

Part II – Social History Interview

Section A – Participant Information	
Name of participant	Date of interview *(month, day, year)*
Current school / child care provider of participant	
Local public school district of residence	

Section B – Reason for Referral to First Steps
Review the reason(s) for referral with the family members. Include medical condition / diagnosis requiring assistance.

Section C – Health Care Received in the Past Twelve (12) Months		
List Primary care physician for all well-child care including immunizations and illness, dentist, and medical care by specialty type. Copy additional pages of this section as needed.		
Name of primary care physician	Telephone number ( )	Fax number ( )
Address *(number and street, city, state, and ZIP code)*		Date last seen *(month, day, year)*
Name of physician	Telephone number ( )	Fax number ( )
Address *(number and street, city, state, and ZIP code)*		Date last seen *(month, day, year)*
Physician specialty *(check one)* ☐ Well child care / clinic services ☐ Vision ☐ Hospital / Emergency Room ☐ Specialty *(type)* _____		
Name of physician	Telephone number ( )	Fax number ( )
Address *(number and street, city, state, and ZIP code)*		Date last seen *(month, day, year)*
Physician specialty *(check one)* ☐ Well child care / clinic services ☐ Vision ☐ Hospital / Emergency Room ☐ Specialty *(type)* _____		
Name of dentist	Telephone number ( )	Fax number ( )
Address *(number and street, city, state, and ZIP code)*		Date last seen *(month, day, year)*

Section D – What is happening now for the participant and family?

1. What kinds of support and community resources are presently being used by your family and/or child?
For each item below, indicate "C" for Currently enrolled or "P" for Pending and include the date of application.

Family / Child Services		Economic Support Services	
Adoption Services		Temporary Assistance for Needy Families (TANF)	
Child Care Assistance		Food Stamps	
Employment Services		Women, Infants, and Children (WIC)	
Legal Services		Supplemental Security Income (SSI)	
Children's Special Health Care Services (CSHCS)		Housing	
Medicaid		Utility Assistance	
Other: _____		Other: _____	

2. Discuss referral to community resources with family for any "Yes" responses.

Do you need assistance with:

a. Housing / utility needs? ☐ Yes ☐ No
b. Transportation to get you to appointments, health care, or other services? ☐ Yes ☐ No
c. Help with providing food or nutritional advice for your family / child? ☐ Yes ☐ No
d. Support with other issues such as parenting, family relations legal issues, or general personal safety? ☐ Yes ☐ No
e. Are there health care or other special health issues that you need help with for any member? ☐ Yes ☐ No
If yes, describe: _____

Section D – What is happening now for the participant and family? *(continued)*

3. What type(s) of adaptive equipment is currently used by your child? *(Check all that apply.)*

☐ Wheelchair ☐ Walker ☐ Splints/AFO's (ankle, foot, orthosis) ☐ Eyeglasses
☐ Adaptive Seating ☐ Adaptive Bathing ☐ Assistive Communication Device(s) ☐ Braces
☐ Feeding Aids ☐ Hearing Aids ☐ Other: _____ ☐ Other:_____

4. What medical / health equipment / supplies are routinely used by your child? *(Check all that apply.)*

☐ Apnea monitor ☐ Oxygen ☐ Tube Fed ☐ Prescription Drugs
☐ Ventilator Dependent ☐ Other: _____ ☐ Other: _____

5. Current Medications *(Specify dosage, frequency, and purpose.)*

Medication	Dosage	Frequency	Purpose

6. Special diet? ☐ Yes ☐ No

If yes, describe

7. Describe any allergies.

Section E – Pregnancy, Birth, and General Health History

Is there anything important about the pregnancy with this child, or his/her birth or early health history that would be helpful to us in determining your child's eligibility of planning services together? ☐ Yes ☐ No

If the family member reports "Yes" conduct the in-depth interview as follows. This information is often not available from families who have adopted children. Check all appropriate boxes.

1. Foster child? ☐ Yes ☐ No — Age at DFR placement

2. Child was adopted? ☐ Yes ☐ No — Age at adoption

3. What month of the pregnancy did you start to see a medical provider?

Did you have regular medical care during this pregnancy? ☐ Yes ☐ No

4. During the pregnancy with this child, were any of the following present?

☐ Anemia ☐ Early Contractions ☐ Heart Disease ☐ Non-prescription drugs ☐ Toxemia
☐ Alcohol ☐ Injury ☐ Elevated Blood Pressure ☐ Prescription drugs ☐ Vomiting
☐ Bleeding ☐ Kidney Disease ☐ Swollen ankles ☐ Early bed rest ☐ Flu
☐ Measles ☐ German Measles ☐ Threatened miscarriage ☐ Virus (type): _____
☐ Other illness *(type)*: _____
☐ Other illness *(type)*: _____

Comments

5. Type of delivery
☐ Vaginal ☐ Breech ☐ Twin ☐ Cesarean ☐ Premature ☐ Other _____

Comments

6. Was any anesthesia used during childbirth? ☐ Yes ☐ No — If yes, type of anesthesia

7. Were there any problems/complications *during* delivery for the mother? ☐ Yes ☐ No — If yes, explain

Were there any problems/complications *during* delivery for the child? ☐ Yes ☐ No — If yes, explain

8. Were there any problems/complications *after* delivery for the mother? ☐ Yes ☐ No — If yes, explain

Were there any problems/complications *after* delivery for the child? ☐ Yes ☐ No — If yes, explain

Length of stay for child

Length of stay for mother

Section E – Pregnancy, Birth, and General Health History *(continued)*

9. Newborn status

☐ Healthy, no problems ☐ Breathing problems ☐ Cord around neck ☐ Jaundice ☐ Delayed crying
☐ Irregular heart beat ☐ Low birth weight ☐ Seizures ☐ Ventilator - How long? _____
☐ Other: _____

10. What was the child's birth weight?	11. Where was the child born? *(Name of hospital, city, and state)*

12. Was the child transferred to another hospital? ☐ Yes ☐ No	If yes, which hospital?

13. How has your child's general health been since birth?

☐ Healthy, no problems ☐ Numerous ear infections ☐ Sleeping problems ☐ Surgery(ies)
☐ Feeding problems ☐ Repeated hospitalizations ☐ Vomiting problems
☐ Other: _____
☐ Other: _____

Note below any additional information including discharge summary or reports provided during this interview.

Name of participant

Section F – Developmental Milestones

This is a list of developmental milestones. Please indicate if your child/participant is able to perform each of the following skills. Please check "Yes" if he or she can perform the skill without help, "With Help" if he or she needs assistance, or "No" if your child cannot perform the skill. Note: Foster/Adoptive Parent may not have the following detailed information. Provide as much information as possible.

Chronological age of child	Adjusted age of child	Currently in NICU? ☐ Yes ☐ No

Gross Motor Skills: *to sit up, move around, and play physical games*

	Yes	With help	No		Yes	With help	No
Holds head steady	☐	☐	☐	Pulls to standing	☐	☐	☐
Rolls Over	☐	☐	☐	Walks	☐	☐	☐
Sits	☐	☐	☐	Goes up/down stairs	☐	☐	☐
Crawls on hands and knees	☐	☐	☐	Walks while carrying toys	☐	☐	☐

Comments _____

Fine Motor Skills: *to use arms and hands to reach, grasp, and play with objects and toys*

	Yes	With help	No		Yes	With help	No
Reaches toward person or object	☐	☐	☐	Unfastens clothing	☐	☐	☐
Grasps large objects	☐	☐	☐	Plays with toys / objects in a coordinated manner	☐	☐	☐
Grasps small objects	☐	☐	☐				
Marks on paper with crayon, etc.	☐	☐	☐				

Comments _____

Communication Skills: *to understand others, to express his or her own thoughts*

	Yes	With help	No		Yes	With help	No
Looks toward face or sound	☐	☐	☐	Uses words to make requests	☐	☐	☐
Smiles	☐	☐	☐	Understands simple directions	☐	☐	☐
Babbles (uses no words yet)	☐	☐	☐	Uses simple sentences	☐	☐	☐
Uses gestures to communicate	☐	☐	☐	Starts or continues conversation	☐	☐	☐
Understands "no" + name	☐	☐	☐				

Comments _____

Adaptive Skills: *to feed, bathe, dress, and toilet him/her self*

	Yes	With help	No		Yes	With help	No
Eats from bottle or breast	☐	☐	☐	Removes clothing	☐	☐	☐
Cooperates in washing at bath time	☐	☐	☐	Uses utensils to feed self	☐	☐	☐
Cooperates in dressing	☐	☐	☐	Indicates need for toileting	☐	☐	☐

Comments _____

Social-Emotional Skills: *to develop positive social relationships*

	Yes	With help	No		Yes	With help	No
Responds to adult interaction	☐	☐	☐	Initiates and maintains positive social games	☐	☐	☐
Tries to attract adult attention with movement or vocalization	☐	☐	☐	Shares with peers	☐	☐	☐
				Solves problems in interactions with others	☐	☐	☐
Plays by self with toys for short time (10-15 minutes)	☐	☐	☐				

Comments _____

Cognitive and Learning Skills: *to gain knowledge and solve problems*

	Yes	With help	No		Yes	With help	No
Responds to sensory stimuli (noise, light, touch)	☐	☐	☐	Recognizes name in print	☐	☐	☐
				Plays simple imaginary games	☐	☐	☐
Imitates pat-a-cake or other familiar games	☐	☐	☐	Can tell what happened or what was said earlier	☐	☐	☐
Looks for toys in familiar places	☐	☐	☐				

Comments _____