

## CHILD SERVICE COORDINATION PROGRAM STATUS

1. Last Name	First Name	MI
2. Patient Number	<b>H</b>	
3. Date of Birth	Month	Day
	1	9
	Year	
4. Race 1 = White 2 = Black 3 = Am. Ind./Alaskan Native 4 = Asian/Pacific Islander <input type="checkbox"/>		
5. Ethnicity: Hispanic Origin? 1 = Yes 2 = No <input type="checkbox"/>		
6. Special Populations:		
Migrant Farmworker/Dependent? (Y/N) <input type="checkbox"/>	Country of Origin: <input type="checkbox"/>	
Seasonal Farmworker/Dependent? (Y/N) <input type="checkbox"/>	1=Mexico	
English Speaking? (Y/N) <input type="checkbox"/>	2=Haiti	
Homeless? (Y/N) <input type="checkbox"/>	9=Other – All others	
Refugee? (Y/N) <input type="checkbox"/>	including USA	
7. Sex: 1 = Male 2 = Female <input type="checkbox"/>		
8. County of Residence: <input type="text"/>		
13. Report Interval: (Required during month of child's birthday if enrolled in CSCP but not I-TP; required at time of closure to either I-TP or CSCP.)		
A = month of 1st birthday    D = month of 4th birthday		
B = month of 2nd birthday    E = Interval other than A-D		
C = month of 3rd birthday    F = month of 5th birthday or older <input type="checkbox"/>		
14. Is this a transfer to another service coordination agency? <input type="checkbox"/>		
(Enter Y for Yes or N for No.)		
If yes, enter 3-digit code for new service coordination agency. <input type="text"/>		
15. (a) Child closed to Child Service Coordination Program: <input type="checkbox"/>		
(Enter Y for Yes or N for No. Go to item 17 if No.)		
(b) Child closed to I-TP: <input type="checkbox"/>		
(Enter Y for Yes or N for No. Go to item 17 if No.)		
16. Reason for closure: (Enter C, R, D, F, M, T, A, E, U, or O) <input type="checkbox"/>		
C = Parent assumes CSC responsibilities		
R = Parent refuses enrollment		
D = Parent discontinues participation		
F = Lost to follow-up		
M = Moved, address unknown or out of state		
T = Transferred to another county of residence		
A = Child aged out of program		
E = Child expired		
U = Unsubstantiated risk factors		
O = Other _____		
17. Child's immunizations are current? <input type="checkbox"/>		
(Enter Y for Yes or N for No.)		
18. Child receiving well child care? (Enter Y for Yes or N for No.) <input type="checkbox"/>		
19. Child receiving WIC Program services? <input type="checkbox"/>		
(Enter Y for Yes or N for No.)		
20. Child has received an Intermediate Assessment since last interval report? (Enter Y for Yes or N for No.) <input type="checkbox"/>		
21. Child has received a Multidisciplinary Evaluation since last interval report? (Enter Y for Yes or N for No.) <input type="checkbox"/>		
22. An Individualized Family Service Plan has been completed or reviewed since last interval report? (Enter Y for Yes or N for No.) <input type="checkbox"/>		
23. An Individualized Education Program has been completed since last interval report? (Enter Y for Yes or N for No.) <input type="checkbox"/>		

9. Child Has: Medicaid? (Y/N) <input type="checkbox"/>			Self-Pay? (Y/N) <input type="checkbox"/>		
Other Insurance? (Y/N) <input type="checkbox"/>			Medicare? (Y/N) <input type="checkbox"/>		
10. Date of Report			Month	Day	Year
11. ID Number Change					
To change patient ID, enter old ID number below					
<input type="text"/>					
12. CSC Agency completing this form <input type="text"/>					
24. Child development status (Report only when Intermediate Assessment or Multidisciplinary Evaluation completed)					
N = Normal					
F = Needs follow-up					
D = Confirmed Diagnosis (only after Multidisciplinary Evaluation) <input type="checkbox"/>					
25. Service Status as indicated by the family – (Check all services family is receiving at this time.)					
<input type="checkbox"/> Nursing Services					
<input type="checkbox"/> Social Work Services					
<input type="checkbox"/> Parent Support Programs					
<input type="checkbox"/> <b>BEGINNINGS</b> Referral					
<input type="checkbox"/> Physical Therapy					
<input type="checkbox"/> Vision Services					
<input type="checkbox"/> Medical (Evaluation) Services					
<input type="checkbox"/> Deaf/HH Interpreter/Transliterater					
<input type="checkbox"/> Transportation					
<input type="checkbox"/> Special Instruction – Home					
<input type="checkbox"/> Genetic Services					
<input type="checkbox"/> Preschool/Program (Part B)					
<input type="checkbox"/> Financial Assistance					
<input type="checkbox"/> Alternative Residential Placement					
<input type="checkbox"/> Family Counseling and Therapy					
<input type="checkbox"/> Supplemental Security Income					
<input type="checkbox"/> Before and After School – Summer Care					
<input type="checkbox"/> Non-English Interpreter/Translator					
<input type="checkbox"/> Psychological Services					
<input type="checkbox"/> Health (Chronic/Acute) Services					
<input type="checkbox"/> Immunizations					
<input type="checkbox"/> Occupational Therapy					
<input type="checkbox"/> Audiological Services					
<input type="checkbox"/> Child Service Coordination					
<input type="checkbox"/> Speech-Language Therapy					
<input type="checkbox"/> Assistive Technology					
<input type="checkbox"/> Well Child Care					
<input type="checkbox"/> Housing					
<input type="checkbox"/> Special Instruction – Center					
<input type="checkbox"/> WIC Program Services					
<input type="checkbox"/> Multidisciplinary Evaluation and Assessment					
<input type="checkbox"/> Nutrition Services					
<input type="checkbox"/> In-Home Support					
<input type="checkbox"/> Respite Care					
<input type="checkbox"/> Child Care					
<input type="checkbox"/> Other; specify _____					

**PURPOSE:** To record information regarding the developmental status and services received by children in the Child Service Coordination Program.

**PREPARATION:** This form is to be completed by the Child Service Coordinator.  
1. Complete during the month of the child's birthday.  
2. Also complete any time the child is transferred to another Child Service Coordinator or when the child is closed to the Child Service Coordination Program.

**DISTRIBUTION:** Part I – Child Service Coordinator  
Part II – County Health Department Data Entry Clerk

**INSTRUCTIONS:** Numbers correspond to item numbers on the front of this form.

1. **Patient's Name:** Enter last name, first name and middle initial.
2. **Patient Number:** Enter the child's HSIS number (social security number).
3. **Date of Birth:** Enter the child's eight-digit date of birth, e.g., May 1, 1993 = 

0	5	0	1	1	9	9	3
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. **Complete only when making a correction.**
4. **Race:** Enter the code number that corresponds to the child's race, e.g., black = 

2
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. **Complete only when making a correction.**
5. **Ethnicity:** Enter the code that corresponds with the child's ethnicity. **Complete only when making a correction.**
6. **Special Populations:** Respond Y or N to all items in this section but country of origin, which requires: 1=Mexico, 2=Haiti or 9=Other as shown. **Complete only when making a correction.**
7. **Sex:** Enter the code number that corresponds to the child's sex., e.g., female = 

2
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. **Complete only when making a correction.**
8. **County of Residence:** Enter the three-digit county code where the child resides. **Complete only when making a correction.**
9. **Child has Medicaid, Other Insurance, Self-Pay, or Medicare:** Respond Y or N to each category.
10. **Date of Report:** Enter the six-digit date that the form was completed, e.g., July 1, 1997 = 

0	7	0	1	9	7
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11. **ID Number Change:** Enter the temporary HSIS ID number.
12. **CSC Agency Completing this Form:** Enter three-digit code of Child Service Coordination Agency completing form.
13. **Report Interval:** Enter the appropriate code, e.g., month of 1st birthday = 

A
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. Option E is restricted to use for any time other than A-D. It should always be utilized at the time of transfer or closure to Infant-Toddler and CSC programs.
14. **Transfer:** Enter Y for Yes or N for No and enter three-digit code for new service coordination agency.
15. (a) **Closed to CSCP:** Enter Y for Yes or N for No.  
(b) **Closed to I-TP:** Enter Y for Yes or N for No.
16. If item 15 = Y, indicate reason for closure (C, R, D, F, M, T, A, E, U, or O).
- 17., 18., 19., 20., 21., 22. and 23. Complete at each interval. Enter Y for Yes or N for No.
24. **Child Development Status:** Complete only after Intermediate Assessment or Multidisciplinary Evaluation.
25. **Service Status:** Complete this section at each interval. Check all services that the family is receiving at this time. Each service is identified in Bulletin No. 15 of the Infant-Toddler Program Manual.

**DISPOSITION:** This form may be destroyed in accordance with the Programs Operational Records Standard of the *Records Disposition Schedule* published by the North Carolina Division of Archives and History.

**REORDER**

**INFORMATION:** Additional copies may be ordered on the REQUISITION FOR CHILDREN AND YOUTH MATERIALS (DHHS 3526) from:

N.C. Department of Health and Human Services  
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Children and Youth Branch  
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