

Application for CSOC Summer Camp Services 2021

Part A: Financial Support toward Summer Camp Tuition

Your child must be determined eligible for Intellectual/Developmental Disability services by CSOC and registered for a Qualified Camp prior to submitting this application. If you do not know your child's CYBER ID, please contact PerformCare at **877-652-7624**. You can also complete the Summer Camp Services application online at www.performcarenj.org/SummerCamp.

Instructions

- 1.) Select a qualified camp from the CSOC approved list available at: www.performcarenj.org/SummerCamp.
- 2.) If the Qualified Camp has determined your child will require the assistance of a **One-to-One Aide/Advocate** to attend camp, **you must complete Part B of this application**. Prior to submitting your request, please contact the One-to-One Aide Provider Agency to make sure the agency you selected can staff your request. The list of CSOC approved providers can be found at: www.performcarenj.org/SummerCamp.
- 3.) Mail the **completed** application along with a **copy of the registration or acceptance letter** from the qualified camp to: **PerformCare, Attn: Summer Camp Services, 300 Horizon Drive, Suite 306, Robbinsville, NJ 08691-1919**. Your application **must be complete and postmarked** or received **no later than May 31, 2021**, to be considered for financial support. Applications will not be accepted after the May 31 deadline. Application status notifications will be mailed after May 31, 2021.

Please Note: **Payment is made to the Qualified Camp the youth attends after camp services are rendered.**

Child Information				
Child's First Name	Child's Last Name	Date of Birth	Zip Code	
Child's CYBER ID#				
Parent/Legal Guardian Information				
Parent/Legal Guardian First Name	Parent/Legal Guardian Last Name			
Address	City	State	Zip Code	County
Phone Number	Email Address			
Qualified Camp Information – Please submit Camp Registration Confirmation with this Application.				
Qualified Camp Name	Camp ID (Found on the Qualified Camp Provider list on our website)			

Camp Address		City	State Zip Code
Camp Phone Number		Camp Email Address	

Type of Camp:

Overnight Camp (select up to 6 days only for reimbursement):

Camp Name:

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Dates:

	to		<i>(not to exceed 6 overnights)</i>
Start Date mm/dd/yy		End Date mm/dd/yy	

Day Camp (select up to 10 days only for reimbursement):

WEEK ONE

Camp Name:

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Dates:

	to		<i>(not to exceed 5 days)</i>
mm/dd/yy		mm/dd/yy	

WEEK TWO

Camp Name:

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Dates:

	to		<i>(not to exceed 5 days)</i>
mm/dd/yy		mm/dd/yy	

Nonconsecutive Dates for Camp: (If youth is not attending 2 full weeks please enter individual dates)

Camp Name:

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Dates:

mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy

Attestation

I hereby attest that by submitting the Application for Financial Support toward Summer Camp tuition, that I have fully registered my youth at the indicated Qualified Camp. I further declare that the information entered in this application is true and accurate to the best of my knowledge.

Parent / Legal Guardian Name	Parent / Legal Guardian Signature	Date

Application for CSOC Summer Camp Services 2021

Part B – Application for One-to-One Aide Services for Summer Camp 2021

If the camp has determined your child will require the assistance of a One-to-One Aide/Advocate to attend camp, you **must complete** this section of the application. You and the camp provider must complete the Child Adaptive Behavior Summary (CABS) together on the following pages in order to apply for One-to-One Aide Services. The camp must retain a copy of the jointly completed CABS.

In addition, a copy of the CABS must be provided to the identified One-to-One Aide Provider Agency as it provides a broad picture of the impact of the child’s disability on daily life for both the child and the caregiver and helps ensure the “best fit” of One-to-One Aide for your child. Please also refer to the Qualified One-to-One Aide provider list available on PerformCare’s website to complete the application – www.performcarenj.org/SummerCamp.

ATTENTION: Due to **high demand** for One-to-One Aides for children attending camp the **last two weeks of August**, CSOC cannot guarantee all requests will be filled. **Your application must be complete in order for it to be processed.**

One-to-One Aide Information - For Day Camp Only

Child Information		
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Child’s First Name	Child’s Last Name	Date of Birth
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Child’s CYBER ID#

One-to-One Aide Provider Information	
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One-To-One Aide Provider Agency Name	Provider ID (Found on the One-to-One Aide Provider list on our website)
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One-To-One Aide Provider Agency Address	City	State	Zip Code
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Agency Contact Person	Phone Number	Email Address
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Attestation	Your application must be complete in order for it to be processed.
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I hereby attest that I have fully registered my youth at the indicated Camp and have confirmed with the One-to-One Provider agency that my child’s needs can be met through their agency. I further declare that the information entered in this application is true and accurate to the best of my knowledge.

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Parent / Legal Guardian Name	Parent / Legal Guardian Signature	Date
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Mail the request to: **PerformCare, Attn: Summer Camp Services, 300 Horizon Drive, Suite 306, Robbinsville, NJ 08691-1919**. This application **must be complete and postmarked** or received **no later than May 31, 2021**, to be considered for One-to-One Aide Services. Application status notifications will be mailed after May 31, 2021. Applications will not be accepted after the May 31, 2021 deadline. If you have any questions, please contact PerformCare at **1-877-652-7624**.

NJ Children's System of Care

Child Adaptive Behavior Summary

A Child Adaptive Behavior Summary (CABS) Form is to be completed with the Camp Provider.

CHILD ADAPTIVE BEHAVIOR SUMMARY (CABS) SECTION OF APPLICATION						
Child Name: _____ <small>First MI Last</small>					Current Age: _____	
ABS Completed By: _____			Date Completed: _____			
Relationship: _____			Phone Number: _____			
SECTION I - ACTIVITIES OF DAILY LIVING						
Remember to rate the child's average functioning at home within the last 6 months . You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.						
EATING	1 Mostly Independent	2 Needs Verbal Prompts Less Than Half of the Time	3 Needs Verbal Prompts More Than Half of the Time	4 Needs Physical Assistance Less Than Half of the Time	5 Needs Physical Assistance More Than Half of the Time	Not Applicable (N/A)
1. Eats with fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeds self with a spoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeds self with fork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cuts food with a knife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Drinks from a cup or glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Additional Information: (Briefly explain any N/A responses)						

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TOILETING	1 Mostly Independent	2 Needs Verbal Prompts Less Than Half of the Time	3 Needs Verbal Prompts More Than Half of the Time	4 Needs Physical Assistance Less Than Half of the Time	5 Needs Physical Assistance More Than Half of the Time	Not Applicable (N/A)
1. Identifies when to use toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Toilets Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Wipes self with toilet paper.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Washes hands after toileting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. (Females) Takes care of menstrual needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Any bladder accidents - Day Time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Any bladder accidents - Night time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Any bowel accidents - Day time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Any bowel accidents - Night time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Use any incontinence products (diapers or similar)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IF YES: Check time(s) of day		<input type="checkbox"/> Day time	<input type="checkbox"/> Night time
Comments/Additional Information: (Briefly describe any N/A response)						
HYGIENE	1 Mostly Independent	2 Needs Verbal Prompts Less Than Half of the Time	3 Needs Verbal Prompts More Than Half of the Time	4 Needs Physical Assistance Less Than Half of the Time	5 Needs Physical Assistance More Than Half of the Time	Not Applicable (N/A)
1. Turns on/regulates water temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Washes and dries hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Washes and dries face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bathes self in bathtub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Bathes self in shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Shampoos hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dries self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Uses deodorant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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HYGIENE	1 Mostly Independent	2 Needs Verbal Prompts Less Than Half of the Time	3 Needs Verbal Prompts More Than Half of the Time	4 Needs Physical Assistance Less Than Half of the Time	5 Needs Physical Assistance More Than Half of the Time	Not Applicable (N/A)
9. Combs/brushes hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Puts toothpaste on brush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Brushes own teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Blows and wipes nose with tissue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shaves self as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Additional Information: (Briefly describe any N/A response) :						
DRESSING	1 Mostly Independent	2 Needs Verbal Prompts Less Than Half of the Time	3 Needs Verbal Prompts More Than Half of the Time	4 Needs Physical Assistance Less Than Half of the Time	5 Needs Physical Assistance More Than Half of the Time	Not Applicable (N/A)
1. Undresses self – (appropriately)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can fasten buttons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can put on clothes with snaps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can pull up/down zippers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Fastens a buckle (i.e., belt buckle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hooks own bra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ties shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Dresses self completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Changes clothing regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Selects seasonal clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Removes socks, hat, and mittens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Additional Information: (Briefly describe any N/A response)						

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SECTION II - COMMUNICATIONS AND SOCIAL BEHAVIORS

Remember to rate the child's average functioning **at home, in school, and in the community** within the **last 6 months**. You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.

COMMUNICATION SKILLS	1 Almost Never (less than 10% of the time)	2 Infrequently (less than 25% of the time)	3 Sometimes (about 50% of the time)	4 Frequently (More than 75% of the time)	5 Most/all of the time (90% or more of the time)
1. Responds appropriately to 'Yes' and 'No' questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Follows simple directions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Follows complex or multistep directions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Communicates basic wants and needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
YES/NO RESPONSE SET:	YES	NO	Comment for each below:		
5. Uses gestures to communicate (such as pointing).	<input type="checkbox"/>	<input type="checkbox"/>			
6. Uses sign language to communicate.	<input type="checkbox"/>	<input type="checkbox"/>			
7. Understands gestures.	<input type="checkbox"/>	<input type="checkbox"/>			
8. Understands signs or sign language.	<input type="checkbox"/>	<input type="checkbox"/>			
9. Answers/able to use a telephone.	<input type="checkbox"/>	<input type="checkbox"/>			
10. Does child use any assistive devices for communication?	<input type="checkbox"/>	<input type="checkbox"/>			
SOCIAL BEHAVIORS	Yes	No	Comments		
Does child have hobbies she or he enjoys?	<input type="checkbox"/>	<input type="checkbox"/>			
Child has the ability to independently make friends and maintain friendships.	<input type="checkbox"/>	<input type="checkbox"/>			
Child is able to sustain a meaningful conversation with his/her same age peers.	<input type="checkbox"/>	<input type="checkbox"/>			
Child exhibits interest in spending time with peers close in age.	<input type="checkbox"/>	<input type="checkbox"/>			
Child keeps secret appropriately and is careful about sharing personal information.	<input type="checkbox"/>	<input type="checkbox"/>			
Child is able to exhibit sympathy and concern for the feelings of friends.	<input type="checkbox"/>	<input type="checkbox"/>			
Child is able to express him/herself when necessary.	<input type="checkbox"/>	<input type="checkbox"/>			
Child is able to appropriately manage anger and frustration.	<input type="checkbox"/>	<input type="checkbox"/>			

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OTHER AREAS OF FUNCTIONING	Yes	No	Comments
1. Child is able to identify preferences (food, TV shows, games)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Child can plan & anticipate future events.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Child will seek assistance from others when needed.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Child is able to take trash out and place in appropriate container.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Child will point to a favorite or interesting object.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Child has hobbies of interest.	<input type="checkbox"/>	<input type="checkbox"/>	
7. Child can set & carry out plans.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Child is able to master simple tasks.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Child is capable of cleaning their own room (putting objects away)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Child seeks peer companions for play.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Child can tell time on digital clock or watch	<input type="checkbox"/>	<input type="checkbox"/>	
12. Child is 3 or more grade levels behind in 2 academic subjects.	<input type="checkbox"/>	<input type="checkbox"/>	
13. Child can communicate primary home address.	<input type="checkbox"/>	<input type="checkbox"/>	
14. Child can identify objects in pictures by pointing or naming.	<input type="checkbox"/>	<input type="checkbox"/>	
15. Child can count from 1 to 10 without mistakes.	<input type="checkbox"/>	<input type="checkbox"/>	
16. Child can match 3 shapes or 3 colors.	<input type="checkbox"/>	<input type="checkbox"/>	
17. Child can identify at least 7 colors.	<input type="checkbox"/>	<input type="checkbox"/>	
18. Child can use time to follow a schedule.	<input type="checkbox"/>	<input type="checkbox"/>	
Additional Comments:			

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COMMUNITY AWARENESS	Yes	No	Comments
1. What activities in the community does the child participate in?			
2. Does the child demonstrate appropriate behavior during these activities?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the child aware of ordinary household dangers such as stairs, cleaning liquids, heaters, stoves and fireplaces?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the child demonstrate awareness of community dangers like road traffic, over-friendliness to strangers?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Can the child make purchases?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Can the child use public transportation?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Can the child tell time?	<input type="checkbox"/>	<input type="checkbox"/>	
8a. Does the child self-administer any prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>	
8b. Describe method of administering medication:			
9. Can this person be left alone/unsupervised for any length of time?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Describe the assistance the child needs to manage money (paying bills, budgeting, etc.)			
Comments:			

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SECTION III - MEDICAL AND BEHAVIORAL FACTORS

Remember to rate the child's average functioning **at home** within the **last 6 months**. You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.

For Medical Risk Conditions, indicate 'yes' only if they have experienced symptoms in the past 6 months, regardless of date of diagnoses. If the child has a past history of the condition/treatment, but does not currently, please indicate 'no' but include details of the history in the comments.

For the section on Trauma and Risk History, please indicate yes if the child has **ever** experienced the item listed. If the child has experienced other types of trauma, please indicate that in the appropriate comment box.

MEDICAL RISK CONDITIONS	Yes	No	Comments
1. Allergies (Medication, Food)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Asthma (inhalers, nebulizers)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Respiratory/ (oxygen, tracheotomy, CPAP)	<input type="checkbox"/>	<input type="checkbox"/>	
4. Gastro-intestinal (feeding/elimination Issues; severe reflux)	<input type="checkbox"/>	<input type="checkbox"/>	
5. Uses colostomy	<input type="checkbox"/>	<input type="checkbox"/>	
6. At risk for aspiration	<input type="checkbox"/>	<input type="checkbox"/>	
7. Uses G-Tube	<input type="checkbox"/>	<input type="checkbox"/>	
8. Coughs or chokes while eating or drinking	<input type="checkbox"/>	<input type="checkbox"/>	
9. Someone else must put food/liquids in mouth	<input type="checkbox"/>	<input type="checkbox"/>	
10. Needs mechanically altered diet (<i>thickened, chopped/ puréed</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
11. Needs medically prescribed diet (<i>fat, sodium, cholesterol</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
12. Displays extreme food/ liquid-seeking behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
13. Dehydration risk/ regularly refuses liquids	<input type="checkbox"/>	<input type="checkbox"/>	
14. Constipation: regularly requires suppository or enema	<input type="checkbox"/>	<input type="checkbox"/>	
15. Requires catheter, dialysis (kidney/urinary disease, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
16a. Epilepsy/seizure disorder? If yes, Type	<input type="checkbox"/>	<input type="checkbox"/>	
16b. Is youth prescribed medication for seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
16c. Date of last seizure, type of seizures, frequency:			
17a. Diabetes? If yes, Type:	<input type="checkbox"/>	<input type="checkbox"/>	
17b. Is youth Insulin dependent?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Does child receive in-home specialized nursing care?	<input type="checkbox"/>	<input type="checkbox"/>	

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MEDICAL RISK CONDITIONS	Yes	No	Comments
19. Other medical conditions requiring assistance: <i>LIST BELOW.</i>			
Comments:			
BEHAVIORAL RISKS	Yes	No	Comments
Behaviors (Directed at Self)			Include frequency and triggers
1. Biting/hitting oneself severely	<input type="checkbox"/>	<input type="checkbox"/>	
2. Head Banging	<input type="checkbox"/>	<input type="checkbox"/>	
3. Inserting harmful objects into body orifices	<input type="checkbox"/>	<input type="checkbox"/>	
4. Skin picking or severe scratching	<input type="checkbox"/>	<input type="checkbox"/>	
5. Pica/consumption of non-edibles	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other:	<input type="checkbox"/>	<input type="checkbox"/>	
Behaviors (Directed at Others)	Yes	No	Include frequency, triggers and which individuals are targeted (i.e., parent, sibling, teacher, strangers)
7. Hitting, biting, or kicking others	<input type="checkbox"/>	<input type="checkbox"/>	
8. Making direct threats of violence	<input type="checkbox"/>	<input type="checkbox"/>	
9. Explosive anger/aggression	<input type="checkbox"/>	<input type="checkbox"/>	
10. Severe defiance/consistent refusal or noncompliance with directions	<input type="checkbox"/>	<input type="checkbox"/>	

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Other Behaviors	Yes	No	If Yes, describe what treatment/services child is receiving, if any
11. Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	
12. Criminal Legal involvement	<input type="checkbox"/>	<input type="checkbox"/>	
13. Problem sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>	
14. Impulsive running off	<input type="checkbox"/>	<input type="checkbox"/>	
15. Frequent wandering away	<input type="checkbox"/>	<input type="checkbox"/>	
16. Unusual climbing behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
17. Property damage	<input type="checkbox"/>	<input type="checkbox"/>	
18. Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	
19. Other:	<input type="checkbox"/>	<input type="checkbox"/>	
TRAUMA AND RISK CONDITIONS	Yes	No	Comments
1. History of physical abuse.	<input type="checkbox"/>	<input type="checkbox"/>	
2. History of sexual abuse.	<input type="checkbox"/>	<input type="checkbox"/>	
3. History of being bullied.	<input type="checkbox"/>	<input type="checkbox"/>	
4. History of serious losses such as death of a sibling or parent.	<input type="checkbox"/>	<input type="checkbox"/>	
5. History of removal from home due to abuse or neglect.	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Concerns	Yes	No	If Yes, describe what treatment/services child is receiving, if any
6. Depression (hopelessness, sadness, mood swings).	<input type="checkbox"/>	<input type="checkbox"/>	
7. Anxiety (excessive worry, panic attacks).	<input type="checkbox"/>	<input type="checkbox"/>	
8. Attention Deficit Hyperactivity Disorder.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Severe mood swings and/or irritability.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Tics, movement disorder.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Seeing or hearing things that are not real, paranoid.	<input type="checkbox"/>	<input type="checkbox"/>	
Comments:			

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SECTION IV - SUPERVISION NEEDS AND USE OF ADAPTIVE EQUIPMENT

Remember to rate the child's average functioning or use of equipment within the **last 6 months**. You may indicate in the comment boxes any additional information such as and whether the child's current abilities or need for adaptive equipment have improved or gotten worse compared to past abilities.

Supervision Needs In the Home	Yes	No		Supervision Needs in the Community	Yes	No
1. Requires age-appropriate supervision	<input type="checkbox"/>	<input type="checkbox"/>		1. Requires age-appropriate supervision	<input type="checkbox"/>	<input type="checkbox"/>
2. 24-hour awake supervision day and night	<input type="checkbox"/>	<input type="checkbox"/>		2. 24-hour awake supervision day and night	<input type="checkbox"/>	<input type="checkbox"/>
3. Close supervision during day	<input type="checkbox"/>	<input type="checkbox"/>		3. Close supervision during day	<input type="checkbox"/>	<input type="checkbox"/>
4. Daily on-site support/supervision, limited hours	<input type="checkbox"/>	<input type="checkbox"/>		4. Can be left alone in specific places	<input type="checkbox"/>	<input type="checkbox"/>
5. Can identify an emergency & get help for self	<input type="checkbox"/>	<input type="checkbox"/>		5. Travels in community independently	<input type="checkbox"/>	<input type="checkbox"/>
6. Requires assistance to evacuate home.	<input type="checkbox"/>	<input type="checkbox"/>		6. Vulnerable to exploitation	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

USES OF ADAPTIVE EQUIPMENT	CHECK IF USES	Comments			
Wheelchair <i>(You may select more than one)</i>	<input type="checkbox"/>	Manual <input type="checkbox"/>	Motorized <input type="checkbox"/>	Self-Propels <input type="checkbox"/>	Requires Assistance <input type="checkbox"/>
Helmet	<input type="checkbox"/>				
Eyeglasses	<input type="checkbox"/>				
Walker/Crutches/Cane	<input type="checkbox"/>				
Modified Eating Utensils	<input type="checkbox"/>				
PERS-Personal Emergency Response System	<input type="checkbox"/>				
Corrective shoes/braces	<input type="checkbox"/>				
Hearing Aid	<input type="checkbox"/>				
Augmentative Communication Device	<input type="checkbox"/>				

NJ Children's System of Care

USES OF ADAPTIVE EQUIPMENT	CHECK IF USES	Comments
Other: Please Describe	<input type="checkbox"/>	
1		
2		
3		
Comments:		
USES OF ENVIRONMENTAL MODIFICATIONS	CHECK IF USES	Comments
Wheelchair Accessible Vehicle	<input type="checkbox"/>	
Accessible Bathroom Facilities	<input type="checkbox"/>	
Ramp	<input type="checkbox"/>	
Lifts: Porch, Hoyer, Stair	<input type="checkbox"/>	
Other: Please Describe	<input type="checkbox"/>	
1		
2		
3		
Comments:		

Discrimination is against the law

PerformCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PerformCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PerformCare reduces language barriers to accessing services through the New Jersey Children's System of Care by:

- Providing free aids and services to people with disabilities to communicate effectively with us, such as:
 - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
 - Telecommunication devices such as Device for the Deaf (TDD) and Text Telephone (TTY) systems to enable individuals who are deaf, hard of hearing, or speech-impaired to use the phone to communicate.
- Providing language services at no cost to people whose primary language is not English, such as:
 - Qualified interpreter services.
 - Information written in other languages.

If you need these services, contact PerformCare at **1-877-652-7624** or [TTY (for the hearing impaired) **1-866-896-6975**]. We are available 24 hours a day, seven days a week.

If you believe that PerformCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can submit a complaint by mail or phone, by either calling PerformCare's Quality department at **1-877-652-7624** or by writing to:

PerformCare
Attn: Quality Department
300 Horizon Center Drive, Suite 306, Robbinsville, NJ 08691

If you need help filing a complaint, PerformCare's Quality department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Multi-language interpreter services

Attention: If you do not speak English, language assistance services are available to you at no cost. Call 1-877-652-7624 (TTY 1-866-896-6975).

Spanish: Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-652-7624 (TTY 1-866-896-6975).

Portuguese: Atenção: Se fala português, encontra-se disponível serviço gratuito de intérprete pelo telefone 1-877-652-7624 (TTY 1-866-896-6975).

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-652-7624 (رقم هاتف الصم والبكم: 1-866-896-6975).

Haitian Creole: Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-652-7624 (TTY: 1-866-896-6975).

Chinese Mandarin: 注意: 如果您说中文普通话/国语, 我们可为您提供免费语言援助服务。请致电: 1-877-652-7624 (TTY 1-866-896-6975)。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-652-7624 (TTY 1-866-896-6975) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-877-652-7624 (TTY 1-866-896-6975)।

French: Attention : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-652-7624 (TTY 1-866-896-6975).

Vietnamese: Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-652-7624 (TTY 1-866-896-6975).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-652-7624 (TTY 1-866-896-6975) पर कॉल करें।

Chinese Cantonese: 注意: 如果您使用粵語, 您可以免費獲得語言援助服務。請致電 1-877-652-7624 (TTY 1-866-896-6975)。

Polish: Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-652-7624 (TTY 1-866-896-6975).

Urdu:

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877-652-7624 (TTY: 1-866-896-6975)۔

Turkish: Dikkat: Türkçe konuşuyorsanız dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-652-7624 (TTY 1-866-896-6975) numaralı telefonu arayın.

Russian: Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-652-7624 (TTY 1-866-896-6975).