

COMPREHENSIVE IBI ASSESSMENT (CIA)

The CIA form templates and instructions are available electronically from your regional IBI coordinator or at the Department of Health and Welfare's external site for Developmental Disability forms. www.healthandwelfare.idaho.gov/site/3465/default.aspx.

The CIA 'e-template' also contains instructions embedded in the form. To access these instructions, press the F1 key while your cursor is in the response field. If there are instructions associated with that field they will 'pop-up'. This function will only work while the form is 'locked'. To lock the form, follow these steps:

1. Go to the View Menu.
2. Select Toolbars.
3. Check Forms. The Forms menu should now appear on the icon section of your screen.
4. Select the padlock icon. A visible square will encompass the padlock icon. The form is now locked.

To cut and paste information into the fields on the revised CIA, unlock the form by clicking on the padlock. Cut and paste, then relock the form. If you are having difficulty with the form, please contact your regional FACS IBI coordinator.

If you are having difficulty access the F1, or if your system is not compatible, there is a version included with our electronic capabilities.

Below are the contents of the F1 field in the CIA:

Name: *Name of child or young adult who will be receiving IBI therapy and consultation*

Date of birth: *month/day/year*

MDI#: *seven digit Medicaid number*

Region: *1 thru 7*

DDA: *Name of Developmental Disability Agency providing IBI*

Assessor(s): *Name of certified IBI person assessing the participant. Assessor must be currently certified in IBI through the DHW.*

Date(s) of Assessment: *Date(s) the assessment is occurring*

DDA Address: *Mailing address of DDA*

List each person living with and relationship to participant:

I. ASSESSMENTS AND RELEVANT HISTORIES

COMPREHENSIVE DEVELOPMENTAL ASSESSMENT

Evaluator:

Name of Assessment:

Date of Report(s):

Summary of the assessment (includes strengths and needs)

MEDICAL

1. Health care practitioner:

Date of Report: *date report completed*

Diagnosis given:

Current medication(s): *list name of medication by manufacturer or generic name*

Vision Status: *e.g., 20/20, cortical blindness, corrected with glasses or contacts, visually impaired with specific diagnosis*

Hearing status: *e.g., level and details of conductive or sensor-neural hearing loss, hearing status, etc...*

How does medical or physical condition affect behavior and/or learning? Implications of medical condition on ability of participant to engage in treatment

How will the information provided above impact the plan you will write for this participant?

How is this pertinent to programming? (e.g., more frequent breaks, avoidance of certain foods, use of devices to compensate for medical problems, etc...)

CURRENT SOCIAL HISTORY (completed within one year)

Evaluator: name of person, including credentials, completing social history

Date of Evaluation: date evaluation completed

Age of onset of developmental disability: specific date that the disability was diagnosed

Family strengths, resources and barriers: List strengths, resources and barriers of the family or environment in which the participant resides. Include natural supports, etc...

SIB-R MADADAPTIVE INDEX

Evaluator: person who administered SIB-R

Date of Evaluation: Date of SIB-R

Respondent: person who acted as Respondent on SIB-R

Maladaptive Index: Maladaptive Behavior Index from SIB-R report

Description of the participant's maladaptive behaviors: List specific behaviors from protocol, when available, such as "banging head against hard surfaces" rather than the general category of "hurtful to self"

EDUCATIONAL AND/OR INFANT TODDLER RECORDS

Dates and summary of records, including IFSP, IEP, evaluations and recommendations: summarize key elements that are pertinent to IBI plan

If participant is on an IEP or an alternative educational support plan, how will this information affect the plan? Through collaboration, DDA IBI plan should complement the Educational Behavior Plan to assure effective therapy across environments.

SPECIFIC SKILL ASSESSMENT (when available)

Assessment: name of test or procedure used to assess skill

Date of Assessment: date of each individual assessment

Assessor: Individual completing assessment and their credentials

Results: Diagnosis, if applicable, and recommendations

Participant's strengths and weaknesses

COMMUNICATION MODE AND FUNCTION

Communication Diagnoses: Diagnoses specific to communication.

Receptive Language Age Equivalency: age-equivalency of Receptive Language from assessment

Expressive language Age-Equivalency: age-equivalency of Expressive Language from assessment

How will this information affect the plan you will write for this participant? How will communication abilities affect IBI plans? If participant received speech/language therapy or behavioral support from another entity, does IBI plan complement this service, including mode of communication?

Are assistive and/or augmentative communication devices being used? Describe

PSYCHOLOGICAL AND/OR PSYCHOMETRIC ASSESSMENTS

by licensed Psychologist (if available)

Evaluator: name of assessor and their credentials

Test instruments: Name of test including revision information. (e.g., WAIS-II I vs. WAIS-R)

CIA F1 narrative 8/09

Date of evaluation: *date evaluation was completed*

Summary: *Name of test or procedure used*

MENTAL HEALTH OR SOCIAL AND EMOTIONAL ASSESSMENT

Evaluator: *name of assessor and credentials*

Test Instrument: *name of test or procedure used*

Summary: *Diagnosis including test results and recommendations*

OTHER RELEVANT ASSESSMENTS

Assessment instrument(s): *name of test or procedure used*

Dates of assessments: *date of report*

Summary: *diagnosis including test results and recommendations*

SUMMARY ANALYSIS OF ASSESSMENTS AND HISTORIES

Incorporate common issues among assessments into a comprehensive, cohesive narrative of the participant's needs

II. INTERVIEWS

Participant cannot be interviewed. Explanation: *every attempt should be made to interview child even if it is believed they have no insight into their own behavior*

Problem Behavior I: *state specifically what the behavior is (e.g., hitting others with an open hand or banging head against hard objects)*

What would you like to get if you had good behavior? *Food, objects, activities, etc...*

PARENT OR LEGAL GUARDIAN INTERVIEW

Name:

Relationship to participant: *e.g., mother, foster parent, brother*

Daily routines

Describe typical day: *if school age, describe a school day and a non-school day*

Sleep habits: *sleep/wake routine*

1. awake: *when participant gets up and stays up*
2. bed time: *when participant is asked to go to bed if inconsistent, what is range: What is the earliest child goes to bed versus the latest? On a school night versus a non-school night?*
3. apnea? *How often up during the night? How regular is the apnea?(e.g., nightly, one time per week, etc)*
4. elimination habits: *is the child toilet trained and have regular bowel and bladder movements or do they have frequent accidents?*

Dietary routines:

1. meal times: *usual time of meals and snacks*
2. food repertory: *What food does the participant usually eat? Do they have a special diet?*
3. supplements: *list any supplements, including vitamins the participant takes on a routine basis*

Problem Behavior 1: *be specific (e.g., hits sibling with closed fist in the face)*

What are possible reinforcers? *Food objects, activities, social, etc...*

OTHER SIGNIFICANT PERSON INTERVIEW

Relationship to participant: *teacher's aide, day care provider, etc...*

Problem behavior 1: *Give a specific description of the problem behavior. What does it look like when it occurs?*

What are possible reinforcers? *Food, objects, activities, etc...*

SUMMARY OF INTERVIEWS: *Summarize all interviews incorporating all hypotheses generated by the interviews into possible explanations of the maladaptive behavior to include specific persons and environments that provoke the response.*

OBSERVATIONS

Where was the observation? *(e.g., classroom B, school gymnasium, home in the back yard, etc...)*

Description of Environment – *specify where the observation occurred and how that environment was structured (i.e., music class at school with 15 other peers versus at home one-on-one with parent, etc.)*

Who was present? *Name and relationship*

Behavior 1

Description of problem behavior: *be specific (e.g., throwing objects at others)*

Number of incidents of Behavior 1 during observation per unit of time: *e.g., 4 incidents per hour of observation, 3 incidents per 30 minute observation, 6 incidents per 45 minute observation, etc.*

SUMMARY OF OBSERVATIONS

Summarize all results including frequency counts, antecedents and consequences for each type of behavior observed. Contrast the differences in environments in the presence and absence of maladaptive behavior. What worked and what didn't?

PAST INTERVENTION AND STRATEGIES

What is the history of informal or formal interventions and/or strategies? *Include formal developmental therapy and other therapies, including intervention at school or informal techniques (e.g., those attempted by family or other adults/authority figures).*

II. CLINICAL OPINION

Behavioral Communicative Intent: *What needs could this behavior be filling?*

List all possible natural reinforcers that are motivating for this participant. *Reinforcers that the child would naturally receive for completing this new or other behavior. (e.g., learning to ask appropriately and getting what they ask for, if appropriate, or learning to make something to eat and then eating it)*

List all possible contrived reinforcers that are motivating for this participant. *Reinforcer that may be provided for an immediate and significantly strong reinforcement to initiate and build upon this new or other behavior. (e.g. stickers, skittles, etc...)*

Summary of clinical opinion: *Summarize history, assessments, interviews, observations, and hypothesis for each behavior for the purpose of designing an intervention strategy.*