



# 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



## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Previous identification number	Type of referral <input type="checkbox"/> New referral <input type="checkbox"/> Re-referral	Date of referral (month, day, year)	
<b>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.</b>					
<b>Maternal and Child Health (MCH)</b>	Are you enrolled in MCH? <input type="checkbox"/> Yes <input type="checkbox"/> No		Identification number		Date of application (month, day, year)
	Status <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reapplication <input type="checkbox"/> Pending <input type="checkbox"/> Current <input type="checkbox"/> Not Applicable				
<b>Children's Special Health Care Services (CSHCS)</b>	Are you enrolled in CSHCS? <input type="checkbox"/> Yes <input type="checkbox"/> No		Identification number		Date of application (month, day, year)
	Status <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reapplication <input type="checkbox"/> Pending <input type="checkbox"/> Current <input type="checkbox"/> Not Applicable				
<b>Hoosier Healthwise</b>	Are you enrolled in Hoosier Healthwise? <input type="checkbox"/> Yes <input type="checkbox"/> No		Identification number		Date of application (month, day, year)
	Status <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reapplication <input type="checkbox"/> Pending <input type="checkbox"/> Current <input type="checkbox"/> 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 <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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
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**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

<i>Please note the amount and frequency of pay for each person.</i>	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:				<b>Total household gross income</b>

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

**Confirmation of Information**

Signature of First Steps intake / service coordinator	Date (month, day, year)
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## 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		
<b>List Primary care physician for all well-child care including immunizations and illness, dentist, and medical care by specialty type.</b> <b>Copy additional pages of this section as needed.</b>		
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) <input type="checkbox"/> Well child care / clinic services <input type="checkbox"/> Vision <input type="checkbox"/> Hospital / Emergency Room <input type="checkbox"/> 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) <input type="checkbox"/> Well child care / clinic services <input type="checkbox"/> Vision <input type="checkbox"/> Hospital / Emergency Room <input type="checkbox"/> 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?			
<b>1. What kinds of support and community resources are presently being used by your family and/or child?</b> <b>For each item below, indicate “C” for Currently enrolled or “P” for Pending and include the date of application.</b>			
<b>Family / Child Services</b>		<b>Economic Support Services</b>	
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: _____	
<b>2. Discuss referral to community resources with family for any “Yes” responses.</b>			
Do you need assistance with: a. Housing / utility needs? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Transportation to get you to appointments, health care, or other services? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Help with providing food or nutritional advice for your family / child? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Support with other issues such as parenting, family relations legal issues, or general personal safety? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Are there health care or other special health issues that you need help with for any member? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____			

Section D – What is happening now for the participant and family? <i>(continued)</i>			
<b>3. What type(s) of adaptive equipment is currently used by your child? (Check all that apply.)</b>			
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Adaptive Seating <input type="checkbox"/> Feeding Aids	<input type="checkbox"/> Walker <input type="checkbox"/> Adaptive Bathing <input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Splints/AFO's (ankle, foot, orthosis) <input type="checkbox"/> Assistive Communication Device(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Braces <input type="checkbox"/> Other: _____
<b>4. What medical / health equipment / supplies are routinely used by your child? (Check all that apply.)</b>			
<input type="checkbox"/> Apnea monitor <input type="checkbox"/> Ventilator Dependent	<input type="checkbox"/> Oxygen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tube Fed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Other: _____
<b>5. Current Medications (Specify dosage, frequency, and purpose.)</b>			
Medication	Dosage	Frequency	Purpose
<b>6. Special diet?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe			
<b>7. Describe any allergies.</b>			

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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<b>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.</b>			
1. Foster child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age at DFR placement	2. Child was adopted? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
4. During the pregnancy with this child, were any of the following present?			
<input type="checkbox"/> Anemia <input type="checkbox"/> Alcohol <input type="checkbox"/> Bleeding <input type="checkbox"/> Measles <input type="checkbox"/> Other illness (type): _____ <input type="checkbox"/> Other illness (type): _____	<input type="checkbox"/> Early Contractions <input type="checkbox"/> Injury <input type="checkbox"/> Kidney Disease <input type="checkbox"/> German Measles	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Threatened miscarriage	<input type="checkbox"/> Non-prescription drugs <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Early bed rest <input type="checkbox"/> Virus (type): _____ <input type="checkbox"/> Toxemia <input type="checkbox"/> Vomiting <input type="checkbox"/> Flu
Comments			
5. Type of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Breech <input type="checkbox"/> Twin <input type="checkbox"/> Cesarean <input type="checkbox"/> Premature <input type="checkbox"/> Other _____			
Comments			
6. Was any anesthesia used during childbirth? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type of anesthesia	
7. Were there any problems/complications <i>during</i> delivery for the mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, explain	
Were there any problems/complications <i>during</i> delivery for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, explain	
8. Were there any problems/complications <i>after</i> delivery for the mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, explain	
Were there any problems/complications <i>after</i> delivery for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, explain	
Length of stay for child		Length of stay for mother	

<b>Section E – Pregnancy, Birth, and General Health History <i>(continued)</i></b>			
9. Newborn status <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Healthy, no problems</div> <div style="width: 50%;"><input type="checkbox"/> Breathing problems</div> <div style="width: 50%;"><input type="checkbox"/> Cord around neck</div> <div style="width: 50%;"><input type="checkbox"/> Jaundice</div> <div style="width: 50%;"><input type="checkbox"/> Delayed crying</div> <div style="width: 50%;"><input type="checkbox"/> Irregular heart beat</div> <div style="width: 50%;"><input type="checkbox"/> Low birth weight</div> <div style="width: 50%;"><input type="checkbox"/> Seizures</div> <div style="width: 50%;"><input type="checkbox"/> Ventilator - How long? _____</div> <div style="width: 50%;"><input type="checkbox"/> Other: _____</div> </div>			
10. What was the child's birth weight?	11. Where was the child born? <i>(Name of hospital, city, and state)</i>		
12. Was the child transferred to another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which hospital?		
13. How has your child's general health been since birth? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Healthy, no problems</div> <div style="width: 50%;"><input type="checkbox"/> Numerous ear infections</div> <div style="width: 50%;"><input type="checkbox"/> Sleeping problems</div> <div style="width: 50%;"><input type="checkbox"/> Surgery(ies)</div> <div style="width: 50%;"><input type="checkbox"/> Feeding problems</div> <div style="width: 50%;"><input type="checkbox"/> Repeated hospitalizations</div> <div style="width: 50%;"><input type="checkbox"/> Vomiting problems</div> <div style="width: 50%;"><input type="checkbox"/> Other: _____</div> <div style="width: 50%;"><input type="checkbox"/> Other: _____</div> </div>			

***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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulls to standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolls Over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goes up/down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawls on hands and knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walks while carrying toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unfastens clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasps large objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plays with toys / objects in a coordinated manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasps small objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Marks on paper with crayon, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses words to make requests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Understands simple directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babbles (uses no words yet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses simple sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses gestures to communicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Starts or continues conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understands “no” + name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Removes clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperates in washing at bath time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses utensils to feed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperates in dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indicates need for toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments \_\_\_\_\_

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

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

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognizes name in print	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Plays simple imaginary games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imitates pat-a-cake or other familiar games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can tell what happened or what was said earlier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looks for toys in familiar places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Comments \_\_\_\_\_