Sensory and Communication Module

Commented [SL1]: The module document is a reference for automation. If the CCM tool provides a different method to improve user efficiency (e.g. navigation, workflow, layout) this should be reviewed with the Department for optimization within the CCM platform. This document is a not intended to be automated as is.

This module is for participants age 13 and older.
For participants age 0-12, display the age specific items within the Sensory and Communication Module Supplement as described in Functional Communication Section.

Key
Bold Blue Highlight: Module narrative and directions- assessment level instructions and/or help
Orange: Items, responses, and other language specifically for participants 0-17 unless otherwise indicated
Green: Skip patterns
Red: Additional instructions for assessors – item level help
Purple: Section level help
Light Blue: Notes for automation and/or configuration
S **Denotes a shared question with another module (one way only unless otherwise indicated)**
Gray Highlight: Responses/Text Boxes to pull forward to Assessment Output
Yellow Highlight: populate and/or pull forward to the support plan from another module or section within the support plan itself
Green Highlight: Populate and/or pull forward from the member record to an assessment or from an assessment to the member record
Denotes mandatory item
Item populates forward for Reassessment
Teal Highlight: Items for Revision and CSR – Support Plan only
Italics: Items from FASI (CARE) - for Department use only

The purpose of the Sensory & Communication module is to document whether the participant has any sensory or communication needs that affect functioning, health or safety; the type of adaptive equipment, technology or environmental modifications used and/or needed; and implications for support planning. This module also identifies the need to refer the participant for other professional assessment(s) or to other supports available in the community to assist with improving and maintaining function.

Notes/Comments are present at the end of each section. These are used to:
1. Document additional information that was discussed or observed during the assessment process and was not adequately captured.
2. Document unique behavioral, cognitive or medical issue that were not captured in the assessment items that may increase the need for supervision or support. This narrative can provide additional justification in the event of a case review

1. VISION & VISION DEVICES

Commented [SL2]: Within the CCM tool numbering for sections and questions does not need to match document, however format needs to be determined by the Department based on CCM design

1. **Does participant have or need any vision devices?**
   - ❍ **No** (Skip to item 2- Ability to see)
   - ❍ **Yes**

In **Use of Device** column use the following responses:

- ***Assistive device needed and available-*** *Participant needs this device to complete daily activities and has the device in the home*
- ***Assistive device needed but current device unsuitable-*** *Devices is in home but no longer meets participant's needs*
- ***Assistive device needed but not available-*** *Participant needs the device but it is not available in the home*
- ***Participant refused-*** *Participant chooses not to use needed device*

Type of Assistive Device	**Use of Device (Drop down)**	**Comments/Supplier**
Glasses	Drop Down	
Contacts	Drop Down	
Eye patch	Drop Down	
Hand reader or stand magnifier	Drop Down	
Projection devices	Drop Down	
Strong convex lenses	Drop Down	
Distance magnifiers	Drop Down	
Reading rectangle	Drop Down	
Computer software (i.e., for screen magnification such as Zoomtext, Magic, or screen reading, such as JAWS)	Drop Down	
Computer output device (refreshable Braille display)	Drop Down	
Computer input devices (switches, buttons, adaptive key strokes, EyeGaze)	Drop Down	
CCTV (closed circuit TV for magnification of print materials)	Drop Down	
Books on tape/CD/Audio books	Drop Down	
Orbital Implant	Drop Down	
Tactile or Braille markings for appliances/ other IADL items	Drop Down	
Talking watch/clock	Drop Down	
Talk to text	Drop Down	
Large number phone	Drop Down	

Type of Assistive Device	**Use of Device (Drop down)**	**Comments/Supplier**
Large Visual Display (LVD) for TTY	Drop Down	
Medical phone alert system	Drop Down	
Long or folding cane	Drop Down	
Service animal (e.g., guide dog)	Drop Down	
Other Specify other Vision Device/Aid: _____	Drop Down	

2. Ability to see in adequate light (with glasses or other visual devices and aids):

- ❍ Adequate: sees fine detail, including regular print in newspapers/books [Skip to Notes and Comments- Vision]
- ❍ Mildly to moderately impaired: Can identify objects; may see large print
- ❍ Severely impaired: No vision or object identification questionable
- ❍ Unable to determine

3. Issues related to vision:

- ☐ Cataracts
- ☐ Congenital blindness
- ☐ Cortical blindness
- ☐ Decreased Side Vision - Left
- ☐ Decreased Side Vision - Right
- ☐ Diabetic retinopathy
- ☐ Eye movement disorders
- ☐ Farsighted
- ☐ Glaucoma
- ☐ Halos or rings around light, curtains over eyes, or flashes of lights
- ☐ Intermittent Exotropia
- ☐ Legally Blind (even with the use of glasses or contacts)
- ☐ Macular degeneration
- ☐ Nearsighted
- ☐ Night Blindness (unable to functionally see in dark environments)
- ☐ Problems with Depth Perception
- ☐ Retinitis Pigmentosa
- ☐ Tunnel Vision
- ☐ Other
  Describe other issues related to vision: _____
- ☐ None

4. Participant uses vision assistive devices as prescribed/recommended:
- ❍ No
  Describe why participant does not use vision assistive device(s) as prescribed/recommended: _____
- ❍ Yes
- ❍ Unknown

5. Participant needs help using vision assistive device(s):
- ❍ No
- ❍ Yes
  Describe help needed using vision assistive device(s): _____

6. Assistive device(s) meet the participant's vision needs:
- ❍ No
  Describe why vision assistive device(s) fails to meet the participant's needs: _____
- ❍ Yes
- ❍ Unknown

7. Participant can find his/her way in unfamiliar environments independently, including with assistive device(s):
- ❍ No
- ❍ No, but not due to vision
- ❍ Yes [Skip to Item 10- Vision become worse]
- ❍ Unknown

8. Participant is currently receiving orientation or mobility training:
- ❍ No
- ❍ Yes
  Describe orientation or mobility training participant is currently receiving: _____ [Skip to Item 10- Vision become worse]
- ❍ Unknown

9. Participant would like to receive orientation or mobility training:
- ❍ No
  Describe why participant does not want to receive orientation or mobility training: _____
- ❍ Yes [Provide referral to Division of Vocational Rehabilitation (DVR); Colorado Center for the Blind; and/or Colorado School for Deaf and Blind as appropriate]

Commented [SL3]: If "yes" as task will be generated to make a referral.

10. Has your/your child's vision become worse in the last 3 months, or since the last assessment?
- ❍ No
- ❍ Yes- consider a referral for further vision or medical assessment
- ❍ N/A (e.g. blind)

❍ Unknown- consider a referral for further vision or medical assessment

11. Notes/Comments: Vision & Vision Devices

2. HEARING & HEARING DEVICES

1. Does the participant have or need any hearing devices?
- ❍ **No** (Skip to item 2- Ability to Hear)
- ❍ **Yes**

In **Use of Device** column use the following responses:
- ***Assistive device needed and available-*** *Participant needs this device to complete daily activities and has the device in the home*
- ***Assistive device needed but current device unsuitable-*** *Devices is in home but no longer meets participant's needs*
- ***Assistive device needed but not available-*** *Participant needs the device but it is not available in the home*
- ***Participant refused-*** *Participant chooses not to use needed device*

Type of Assistive Device	Use of Device (Drop down)	Comments/Supplier
Hearing aid- left	Drop Down	
Hearing aid- right	Drop Down	
Cochlear implant(s)	Drop Down	
Bone anchored hearing aid (BAHA) implant(s)	Drop Down	
FM sound system	Drop Down	
Infra-red sound system	Drop Down	
Service animal	Drop Down	
Alerting devices for phone and doorbell ringing, smoke detectors, etc.	Drop Down	
Closed captioning	Drop Down	
Adaptive phone/texting	Drop Down	
Assistive listening device	Drop Down	
Other,	Drop Down	

Type of Assistive Device	Use of Device (Drop down)	Comments/Supplier
Specify other hearing device/aid: _____		

2. Ability to hear (with hearing aid or hearing device, if normally used):
- ❍ Adequate: hears normal conversation and TV without difficulty [Skip to Notes & Comments: Hearing]
- ❍ Mildly to moderately impaired: Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
- ❍ Severely impaired: Absence of useful hearing
- ❍ Unable to determine

3. Participant uses hearing assistive devices as prescribed/recommended:
- ❍ No
  Describe why participant does not use hearing assistive device(s) as prescribed/recommended: _____
- ❍ Yes
- ❍ Unknown

4. Participant needs help using hearing assistive device(s):
- ❍ No
- ❍ Yes
  Describe help needed using hearing assistive device(s): _____

5. Assistive device(s) meet the participant's hearing needs:
- ❍ No
  Describe why hearing assistive device(s) fail to meet the participant's needs: _____
- ❍ Yes
- ❍ Unknown

6. Has your/your child's hearing become worse in the last 3 months, or since the last assessment?
- ❍ No
- ❍ Yes- consider a referral for further hearing or medical assessment
- ❍ Unsure- consider a referral for further hearing or medical assessment
- ❍ N/A (e.g. deaf)

7. Notes/Comments: Hearing & Hearing Devices

3. FUNCTIONAL COMMUNICATION & FUNCTIONAL COMMUNICATION DEVICES

1. Does the participant have or need any functional communication devices?
- ❍ No (Skip to item 2-Understanding verbal content)
- ❍ Yes

In **Use of Device** column use the following responses:
- ***Assistive device needed and available-*** *Participant needs this device to complete daily activities and has the device in the home*
- ***Assistive device needed but current device unsuitable-*** *Devices is in home but no longer meets participant's needs*
- ***Assistive device needed but not available-*** *Participant needs the device but it is not available in the home*
- ***Participant refused-*** *Participant chooses not to use needed device*

Type of Assistive Device	Use of Device (Drop down)	Comments/ Supplier
Low-tech communication board (e.g., point board)	Drop Down	
Voice output application/speech generating device	Drop Down	
iPad/Tablet	Drop Down	
Other, Specify other functional communication device: _____	Drop Down	

2. Understanding verbal content (excluding language barriers):
- ❍ Understands: Clear comprehension without cues or repetitions
- ❍ Age appropriate difficulty with understanding verbal content
- ❍ Usually understands: Understands most conversations but misses some part/intent of message. Requires cues at times to understand

- ❍ Sometimes understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
- ❍ Rarely/Never understands
- ❍ Unable to determine

3. Participant's ability to express ideas and/or wants with individuals he/she is familiar with. (Shared from LOC)

- ❍ Expresses complex messages without difficulty and with speech that is clear and easy to understand
- ❍ Age appropriate difficulty with expressing needs and/or ideas
- ❍ Exhibits some difficulty with expressing needs and/or ideas (e.g., some words or finishing thoughts) or speech is not clear
- ❍ Frequently exhibits difficulty with expressing needs and/or ideas
- ❍ Rarely/never expresses self or speech is very difficult to understand
- ❍ Unable to determine

4. Participant's ability to express ideas and/or wants with individuals he/she is NOT familiar with.

- ❍ Expresses complex messages without difficulty and with speech that is clear and easy to understand
- ❍ Age appropriate difficulty with expressing needs and/or ideas
- ❍ Exhibits some difficulty with expressing needs and/or ideas (e.g., some words or finishing thoughts) or speech is not clear
- ❍ Frequently exhibits difficulty with expressing needs and/or ideas
- ❍ Rarely/never expresses self or speech is very difficult to understand
- ❍ Unable to determine

5. Describe the nature of the difficulty of expressing ideas and/or wants:

- ☐ No difficulty expressing ideas and/or wants (Skip to Item 7- Use Augmentative Communication Device)
- ☐ No functional communication
- ☐ No functional expressive language
- ☐ Non-verbal
- ☐ Speech impairment (articulation)
- ☐ Speech impairment (functional expressive language)
- ☐ Receptive language impairment (inability to comprehend spoken language)

6. Primary cause of the identified difficulties:

- ☐ Cognitive issues
- ☐ Deaf
- ☐ Hard of hearing
- ☐ Motor issues (e.g., cerebral palsy, etc.)
- ☐ Neurological issues (e.g., seizures, aphasia, apraxia)

- ☐ Physical/medical issues (e.g., after laryngectomy)
- ☐ Psychiatric issues (e.g., echolalia)
- ☐ Other
  Describe primary cause of identified difficulties: _____

7. Type of augmentative communication device(s) participant uses:

Ability to select multiple applicable devices. [For all other than none Skip to Item 9 - Participant needs any of the following to use the augmentative communication device]

- ☐ Alpha Smart
- ☐ Alpha Talker
- ☐ Artificial Larynx
- ☐ Big Mack Switch
- ☐ Braille Screen Communicator
- ☐ Cheap Talk
- ☐ Computer/Cell phone applications (e.g., Skype/Facetime)
- ☐ Dynamite
- ☐ Dynavox
- ☐ Electric Output Device
- ☐ Link Assistive Device
- ☐ Lite writer
- ☐ Mini Message Mate
- ☐ PECS
- ☐ Pocket Talker
- ☐ Speak Easy
- ☐ Tablet (Including iPad and Smartphone)
- ☐ TTY
- ☐ Video relay service
- ☐ Voice Photo Album
- ☐ Voice Recognition Software
- ☐ Other Personal Listening Device
  Describe other personal listening device: _____
- ☐ Other Picture Systems
  Describe other picture systems_____
- ☐ Other type of communication device:
  Describe other type of communication device: _____
- ☐ None

Commented [SL5]: Reference Configuration Spreadsheet for definitions of each type of augmentative communication device to include in item response option.

(Only show when "None" response is selected in item "Type of augmentative communication device)

8. Participant would like to have an augmentative communication device:
(Augmentative communication includes communication devices that are used to express thoughts, needs, wants, and ideas.)

- ❍ No [Skip to Item 11- Harder to be understood]
- ❍ Yes, and needs a referral [Staff should make referral to Speech Language Pathologist] [Skip to Item 11- Harder to be understood]

Commented [SL9]: If "yes but would like to and/or needs referral" a task will be generated to make a referral.

9. Participant needs any of the following to use the augmentative communication device:

- ☐ Back up device when primary device is in for repair/maintenance
- ☐ Training
  Describe training needed for device(s): _____
- ☐ Support or assistance,

Describe support or assistance needed for device(s): _____

☐ Other,

Describe other needs for use of device(s): _____

☐ None apply

10. Assistive device(s) meets the participant's communication needs:

❍ No

Describe why assistive device(s) fail to meet the participant's needs: _____

❍ Yes

❍ Unknown

11. Has it become harder for you/your child to understand others or be understood in the last 3 months, or since the last assessment?

❍ No

❍ Yes- consider a referral for further communication or medical assessment

❍ Unsure- consider a referral for further communication or medical assessment

For participants age 0-12, display the age specific section within the 'Sensory and Communication Supplement' module

12. Notes/Comments: Functional Communication & Functional Communication Devices

4. SENSORY INTEGRATION

1. Participant demonstrates difficulties or challenges with the following (check all that apply) – (Do not score if consistent with child's age)

☐ Sensory modulation - Is over-reactive to stimuli

☐ Sensory modulation - Is under-reactive to stimuli

☐ Sensory modulation - Craves or seeks out stimuli

☐ Sensory modulation - Does not exhibit startle reflex

☐ Sensory based motor - Dyspraxia (motor coordination)

☐ Sensory based motor - Postural (stabilizing posture)

☐ Sensory discrimination - Visual

- ☐ Sensory discrimination - Auditory
- ☐ Sensory discrimination - Tactile
- ☐ Sensory discrimination - Taste
- ☐ Sensory discrimination - Smell
- ☐ Sensory discrimination - Position/Movement
- ☐ Sensory discrimination - Interoception (Sense or awareness of the internal state of the body (e.g., hunger, satiation, thirst, body temperature, etc.))
- ☐ None (Skip to Notes/Comments: Sensory Integration)

2. Participant experiences any of the following issues related to sensory input:

- ☐ Anxiety
- ☐ Appears to hear adequately, but have a delayed response to sounds / speech
- ☐ Avoids being touched
- ☐ Avoids or atypically interacts with others
- ☐ Can't keep hands to self
- ☐ Difficulty keeping tongue in mouth
- ☐ Difficulty making transitions from one situation to another
- ☐ Difficulty screening out sights and sounds (visual/auditory stimuli)
- ☐ Difficulty unwinding or calming self
- ☐ Does not maintain eye contact
- ☐ Does not react/respond to familiar voices and/or hearing own name
- ☐ Does not seek comfort from family/caregiver
- ☐ Does not show interest in others
- ☐ Engage in self-injury
- ☐ Engage in self-stimulation
- ☐ Fearful of activities moving through space, such as using an escalator, climbing stairs, etc.
- ☐ Fearful of new tasks and situations
- ☐ Grind, clench teeth
- ☐ Lack of eye tracking
- ☐ Make repetitive vocal sounds – such as humming, throat-clearing, frequent coughing
- ☐ Misjudge force required to open and close doors, give hugs, etc.
- ☐ More clumsy or careless than peers
- ☐ Overly sensitive to touch, movement, sights, lights, or sounds
- ☐ Poor balance
- ☐ Prefer activities that involve swinging, spinning, rocking
- ☐ Puts hand/ fingers in mouth frequently
- ☐ Reject textures of food, clothing
- ☐ Resistant behavior
- ☐ Respond to loud or unexpected noise by becoming upset
- ☐ Rock self, to sleep, in frustration, in comfort, in excitement

- ☐ Smell objects
- ☐ Under-reactive to touch, movement, sights, or sounds
- ☐ Unusually high activity level
- ☐ Unusually low activity level
- ☐ Unusual reaction to pain – doesn't seem to notice
- ☐ Unusual reaction to pain – particularly noticeable reaction
- ☐ Walk on toes
- ☐ Other
  Describe other sensory issue: _____
- ☐ None apply

3. Are there any settings, situations, or people that are particularly challenging for the participant? (Triggers could include crying babies, barking dogs, noisy restaurants)

- ❍ No
- ❍ Yes
  Describe any settings, situations, or people that are particularly challenging for the participant?

4. What types of settings does the participant do particularly well in?

5. Does the participant use any device/intervention to modulate sensory input?

- ☐ Noise canceling headphones
- ☐ Occupational therapy
- ☐ Weighted vest/blanket
- ☐ Safety ear plugs
- ☐ Sensory diet/menu for gaining behavioral control
- ☐ Swings for proprioception stimulation
- ☐ Other
  Describe other device to modulate sensory input: _____
- ☐ None apply

6. Need for referral to address sensory processing challenges/concerns.

- ❍ Diagnosis on record, no referral needed

❍ Signs and symptoms justify referral
❍ Signs and symptoms do not justify referral

Notes/Comments: Sensory Integration