Shawano County Department of Human Services

CCOP (Children's Community Options Program)

Application – 2017

Application Date: _____ Child's Name: _____

Gender: M or F Child's Date of Birth: _____ Current Age: _____

Child's Social Security Number: _____-_____-_____

Parent/Guardian: _____ Address: _____

City: _____ Zip Code: _____ Telephone Number: _____

Best Time to Contact: _____

Optional Information:

Family Structure: ___ Married ___ Single ___ Widowed ___ Divorced ___ Other

Number of Children in the home: _____

Child's diagnosis (check all that apply):

☐ Autism Spectrum Disorder ☐ Blind ☐ Deaf/ Hearing Impaired ☐ Epilepsy

☐ Cerebral Palsy ☐ Developmental Delay ☐ Muscular Dystrophy

☐ Neuromuscular Disorder ☐ Emotional/ Behavioral Disorder – specify: _____

☐ Other _____

What is the name of the doctor/clinic that diagnosed your child with the above diagnosis/ diagnoses? _____

When was your child diagnosed? _____

Child's services/ benefits (check all that apply):

MA Number (Listed as Member ID on Forward Card):_____

Katie Beckett: ☐ Yes ☐ No SSI: ☐ Yes ☐ No County MA: ☐ Yes ☐ No

WIC: ☐ Yes ☐ No

Private Insurance: _____

Does your child receive any kind of service, other than CCOP, from Shawano County Department of Community Programs? ☐ Yes ☐ No

If yes, please check all that apply:

☐ Birth to Three Services ☐ Children's Long-Term Supports Medicaid Waiver

☐ Intensive In-Home Autism Treatment Waiver ☐ In-Home Psychotherapy

☐ Community Options Program Waiver ☐ Outpatient Services

☐ Emergency Mental Health Services ☐ Coordinated Services Team (Wraparound)

☐ Comprehensive Community Services ☐ Case Management Only

Are you on a waiting list for any of the above programs?

☐ Yes ☐ No

Does your child have connections with any other programs/ services? ☐ Yes ☐ No

If yes, please check all that apply.

☐ Department of Social Services ☐ Child Protective Services ☐ Juvenile Justice

☐ School - Individual Education Plan ☐ Other School Supports

☐ Other: _____

Is your child currently enrolled in a public school? ☐ Yes ☐ No

Do you home school your child? ☐ Yes ☐ No

If applicable, when is your child expected to graduate from school? _____

The CCOP Program was created *to enable parents of children with disabilities to care for their children in their own homes rather than placing them in institutions or other out of home placements, thereby enhancing the quality of life; to improve the availability and coordination of community services to families; and to increase the control of families over the types of services and goods provided to them.* s.46.985 (2), Wisconsin statutes.

Answering the following questions with the program purpose in mind will assist us in determining eligibility and identifying your child's needs.

Describe the needs that your child has (items and/or services).

_____
_____
_____

How are the above listed needs directly connected to your child's disability?

_____
_____
_____

If your child needs assistance with any of the identified tasks, please describe how you assist them. If your child is independent, please indicate N/A (not applicable).

Bathing

_____
_____

Grooming

_____
_____

Dressing

_____
_____

Toileting

_____
_____

Eating

_____
_____

Please describe how your child communicates. Are non-family members able to understand your child's mode of communication?

_____
_____
_____
_____

Please describe how your child participates in school. For example: Is he/she able to participate in the regular classroom? Is he/she in the special education room for part of the day?

_____
_____
_____
_____

Please describe how your child gets from one place to another. For example: Is he/she able to walk? Does he/she use a wheelchair? Do you have to lift him/her out of bed?

_____
_____
_____
_____

Please describe how your child interacts with other children.

_____
_____
_____
_____

For children 18 years old and older: Please describe the supports that your child would need to live independently in the community. For example: Would he/she need help with their finances? Would he/she need assistance with cooking and cleaning?

_____
_____
_____
_____

Is your child currently at risk of being placed out-of-home? ☐ Yes ☐ No

If yes, explain.

_____
_____

Please describe any immediate safety risks you have for your child/ family. How are you currently addressing these risks?

_____

_____

What times and days of the week are you generally available for a home visit?

☐ Monday Times available: _____

☐ Tuesday Times available: _____

☐ Wednesday Times available: _____

☐ Thursday Times available: _____

☐ Friday Times available: _____

A case manager will contact you to schedule a home visit. Please note that your child will need to be present for the home visit.

Is there anything else that you would like us to know about your child and/or family?

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

All applications will be reviewed in the order in which they were received. Requests will be considered, placed into categories based on the severity of the need, and then approved based on the severity of the need as well as availability of funds.

_____

For Office Use Only

Date Sent: _____ Staff Initials: _____

Date Received: _____ Staff Initials: _____

Home Visit Date: _____

Eligibility Determination Date: _____ Eligible: ☐ Yes ☐ No

Plan completed: _____