|  |  |
| --- | --- |
| DCF Logo New 2012 - circle version in black only | **CUSTOMER OR COMPANION COMMUNICATION ASSESSMENT AND AUXILIARY AID/SERVICE RECORD** |

**(To be completed by DCF Personnel or the Contracted Client Services Provider for each service date)**

|  |  |  |
| --- | --- | --- |
| Region/Circuit/Institution: For example: If you work in Pensacola, enter “Northwest Region/Circuit 1” If you work at Florida State Hospital, enter “Northwest Region/Circuit 2/FSH If you’re a provider in Northwest Region, enter “Northwest Region/Circuit Number/Provider Name      | Program: For example:  Enter ACCESS, Mental Health, etc. | Subsection:      |

A **Customer** is any individual seeking or receiving services from the Department or any of its Contracted Service Providers. A **Companion** is any individual who is deaf or head-of-hearing and who communicates with the Department or any of its Contracted Service Providers on behalf of a Customer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Customer [ ]  Companion | Name:      | Date of Contact:      | Time:      | Case No.:      |
| Check one box only.[ ]  Deaf (a person with total hearing loss requiring the use of auxiliary aids or services) [ ]  Hard-of-Hearing (a person with some hearing loss requiring the use of auxiliary aids or services) [ ]  Deaf & Low Vision or Blind (a person who is deaf and who also has any loss of vision) [ ]  Hard-of-Hearing & Low Vision or Blind (a person who is hard-of-hearing and who also has any loss of vision) [ ]  Deaf & Limited English Proficient (a person who is deaf and who also does not speak English, or has limited ability to read, speak, write, or understand English) [ ]  Hard-of-Hearing & Limited English Proficient (a person who is hard-of-hearing and who also does not speak English, or has limited ability to read, speak, write, or understand English)  |
| [ ]  Scheduled Appointment [ ]  Non-Scheduled Appointment [ ]  No Show Date/Time:       |
| Name of Staff Completing Form:       |

**Section 1: Communication Assessment**

|  |
| --- |
|  [ ]  Initial (first contact with customer or companion) [ ]  Reassessment (to determine appropriate auxiliary aid or service when communication is not effective after initial assessment, or nature of communication changes significantly after initial assessment) [ ]  Subsequent Appointment |
| Individual Communication Ability: Always consult with Customer or Companion when possible to determine which appropriate auxiliary aids and services are needed to ensure effective communication.      |
| Nature, Length and Importance of Anticipated Communication Situation(s): The assessment shall take into account the nature, length and importance of the communication at issue and anticipated communication situations. Be as detailed as possible, as this will assist in determining whether the communication is aid essential or non-essential. Consult with the customer or companion where possible to determine what type of auxiliary aid or service is needed to ensure effective communication. Use this information to assist in determining whether a communication plan is necessary. Attach additional sheets detailing this information, if desired.      |
|  [ ]  Communication Plan for Multiple or Long-Term Visits Completed [ ]  Not Applicable |
|  [ ]  Aid-Essential Communication Situation [ ]  Non-Aid-Essential Communication Situation |
| Number of Person(s) Involved with Communication:      Name(s):       |
| Individual Health Status for Those Seeking Health Services: Do not use electronic devices or equipment that may interfere with medical or monitoring equipment or which may otherwise constitute a threat to any customer’s medical condition. Provide alternative means to effective communication and document this information in the medical chart or case file. If necessary, complete a communication plan for foreseeable multiple or long-term visits.      |

**Section 2: Auxiliary Aid/Service Requested and Provided**

|  |  |  |
| --- | --- | --- |
| Type of Auxiliary Aid/Service Requested:       | Date Requested       | Time Requested:      |
| Nature of Auxiliary Aid/Service Provided:Sign Language Interpreter: [ ]  Certified Interpreter [ ]  Qualified Staff [ ]  Video Relay Service  [ ]  Video Remote Interpretive Service [ ]  Florida Relay [ ]  Large Print [ ]  Written Material  [ ]  Assistance Filling Out Forms [ ]  CART [ ]  Other:       |
| If interpreter is “No Show,” check appropriate box, and document in Section 3 additional steps taken to secure interpreter as required. If necessary, attach additional sheet to this form to document steps taken.Interpreter Service Status: Arrival Time:       [ ]  Met Expectations of Client [ ]  Met Expectations of Staff [ ]  No Show [ ]  Cancellation:       |
| Alternative Auxiliary Aid or Service Provided, including information on CD or floppy disk, audiotape, braille, large print, or translated materials:“Alternative auxiliary aids or services” are those that might be provided while waiting for an interpreter to arrive, or during non-scheduled appointments or emergency situations, or during non-aid essential communication situations, or during situations that may constitute a threat to the customer’s or companion’s medical condition, or when requested by the customer or companion.      |
| Date and Time Provided:       |

**Section 3: Additional Services Required**

|  |
| --- |
| When it is determined that the auxiliary aid or service provided was not effective, staff shall conduct a reassessment of the communication need to determine the appropriate alternative auxiliary aid. If the interpreter did not meet the staff’s or the customer’s or companion’s expectations, document what additional steps were taken by staff.Was communication effective? [ ]  Yes [ ]  No If not, please explain why communication was not effective.     What action(s) was taken to ensure effective communication?      |

**Section 4: Referral Agency Notification** Provide advance notice to the referral agency(ies) of the Customer’s or Companion’s requested auxiliary aid or service.

|  |
| --- |
| Name of Referral Agency:      |
| Date of Referral:      | Information Provided Regarding Auxiliary Aid or Service Need(s):      |

**Section 5: Denial of Auxiliary Aid/Service by Department**

**Denials should only be made for non-aid essential communication. However, staff must still ensure that effective communication is achieved through whatever alternative means that are provided. Denial determination can only be made by a Regional Managing Director (or designee) Hospital Administrator (or designee) or the Contracted Client Services Provider Administrator (or designee).**

|  |
| --- |
| Reason Requested Auxiliary Aid or Service Not Provided:      |
| Name of Regional Managing Director (or designee) or Hospital Administrator (or designee) or the Contracted Client Services Provider Administrator (or designee) Making Denial Determination:      |
| Denial Date:      | Denial Time:      |

|  |
| --- |
| A communication plan for ongoing services is typically used in Mental Health Treatment Facilities, and other Direct Client Service Facilities where customers reside for long periods of time and or have numerous communications with personnel of varying length and complexity, which are determined as Aid-Essential Communication Situations.The term Aid-Essential Communication Situation shall mean any circumstance in which the importance, length, and complexity of the information being conveyed is such that the exchange of information between parties should be considered as Aid-Essential, meaning that the requested auxiliary aid or service is always provided.Communication situations will differ from program to program. Identify all situations where you will have contact with a Customer or Companion and document in the communication plan on how you will communicate in each situation.**Communication Plan for Ongoing Services** |
| During the initial assessment, or the reassessment, if it is determined that **multiple or long term visits** will be needed, a Communication Plan shall be completed. Services shall continue to be provided to the Customer and Companion during the entire period of the Customer’s hospitalization, residency, long term treatment, or subsequent visits. Discuss with the Customer or Companion their preferred mode of communication in each of the following on-going communication situations and document that communication method in the case plan. The following list is not exhaustive and does not imply there are not other communication situations that may be encountered. Refer to the instructions for further explanation. |

In each situation requiring an Auxiliary Aid (whether Aid-Essential or Non-Aid Essential), identify (1) the type of aid or service; (2) the purpose of the aid or service; and (3) the name and title of the person responsible for ensuring the auxiliary aid or service is provided.

In the following fields, enter more than one paragraph (if necessary) using one of these options:

Option One – To start a new paragraph, hold down the “Shift” key and press the “Enter” key twice, and then type in the new paragraph as in this example; OR,

 Option Two – To start a new paragraph, press the “Enter key once, hold down the “Control” key and press the “Tab” key once, and then type in the new paragraph as in this example.

[ ]  Intake/Interview:

[ ]  Medical:

[ ]  Dental:

[ ]  Mental Health:

[ ]  Safety and Security:

[ ]  Programs:

[ ]  Off Campus Trips:

[ ]  Legal:

[ ]  Food Service/Dietician:

[ ]  Other:

|  |  |
| --- | --- |
| Signature of Person Completing Form: | Date: |
| Signature of Customer or Companion: | Date: |

If the Customer or Companion declines DCF’s or DCF’s Contracted Client Services Provider’s offer to provide free auxiliary aids or services, complete form CF 763, “Customer or Companion Request for Free Communication Assistance or Waiver of Free Communication Assistance.”

DCF staff and DCF Contracted Client Services Providers must be prepared to secure the appropriate auxiliary aid or service in Aid-Essential Communication Situations, and observe and ensure that the Customer’s or Companion’s preferred auxiliary aid or service is effective.

The original copy of this form must be placed in the Customer’s medical chart or case file. Under certain circumstances a copy of the form must be provided to the Single-Point-of-Contact or the designated ADA/Section 504 Coordinator, along with a copy of the corresponding Customer or Com-panion Request for Free Communication Assistance or Waiver of Free Communication Assistance (form CF 763) and the Monthly Summary Report.

|  |
| --- |
| Federal law requires the Florida Department of Children and Families and its Contracted Client Services Providers to furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. Such auxiliary aids and services may include: qualified sign language or oral interpreters, note takers, computer-assisted real time transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, videotext displays, and TTYs. |