SUMMARY OF SCREENING FOR BIE FACE PROGRAM EVALUATION
For Center-based (CB) and Home-based (HB) Children During Program Year 2019 (July 1, 2018 – June 30, 2019)

The intent of this form is to provide a summary of all screening services received during PY19 for ***each*** FACE child. It should be compiled from information collected on several instruments: ASQ-3, ASQ:SE-2, Health Records, and any other screening information. See the FACE Evaluation Data Checklist for information about administration requirements for the instruments.

FACE School _____ Name of Child _____ Child's NASIS # _ _ _ _ _ _ _ _ _

If no screening was conducted for this child during the year, please explain why: _____
_____

Area of Screening	Screened during PY19?			Delays or concerns identified?		Referred for any services?		Received any services?		Agency to which child was referred *(If no agency is available, write NA)*	Were all delays or concerns resolved?		
	Once	*Twice*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*		*Yes*	*No: Service in progress*	*No: Service not in progress*
Communication (ASQ-3, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Gross Motor (ASQ-3, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Fine Motor (ASQ-3, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Problem Solving (ASQ-3, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Personal Social (ASQ-3, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Social Emotional (ASQ:SE-2, required for home-based; as needed for center-based)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
General Health/Medical (from Health Record, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Dental (from Health Record, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Hearing (from Health Record, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Vision (from Health Record, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
Other (describe):	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐

Are the child's immunizations up-to-date (*from Health Record)* ☐ Yes ☐ No

Does the child receive services under the Individuals with Disabilities Educational Improvement Act (IDEIA)?

- ☐ No
- ☐ Yes, the child has an IEP (Individualized Education Plan).
- ☐ Yes, the child has an IFSP (Individualized Family Service Plan).

If yes, please check the child's special needs (check all that apply):

- ☐ Autism
- ☐ Visual impairment, including blindness
- ☐ Deaf-blindness
- ☐ Deafness
- ☐ Emotional disturbance
- ☐ Hearing impairment
- ☐ Intellectual disability (mental retardation)
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Other health impairment (i.e., having limited strength, vitality, or alertness that effects a child's education performance)
- ☐ Traumatic brain injury
- ☐ Other (specify) _____