Support to the Deaf or Hard-of-Hearing

Forms Update 2011

Note: If you are deaf or hard-of-hearing, and need a written copy of the narrative to participate in this training, you can download a copy from the following web address:

http://www.dcf.state.fl.us/admin/servicedelivery/docs/webinar_transcript.pdf

Introduction

Welcome to the Florida Department of Children and Families' on-line instructions for completing the revised **Customer Companion Communication Assessment and related forms.**

Note: If you require special accommodations to participate in this training, please contact your Civil Rights Officer or ADA/Section 504 Coordinator.

During this presentation, the following forms will be discussed:

- Customer or Companion Communication Assessment Auxiliary Aid and Service Record.
- Request for Free Communication Assistance or Waiver of Free Communication.
- Customer / Companion Feedback Form.
- Auxiliary Aid and Service Record Monthly Summary Report.

CUSTOMER or COMPANION COMMUNICATION ASSESSMENT AUXILIARY AID and SERVICE RECORD

CUSTOMER OR COMPANION COMMUNICATION ASSESSMENT AND AUXILIARY AID AND SERVICE RECORD

*This form is completed by DCF Personnel or the Contracted Client Services Provider for each service date.

Region/Circuit/Institution:	Program:	Subsection:	
□ Customer □ Companion Name:	Date:	Time:	Case No.:
□ Deaf □ Hard-of-Hearing □ Deaf and Low Vision or Blind □ Hard-of-Hearing and Low Vision or Blind □ Deaf and Limited English Proficient □ Hard-of-Hearing and Limited English Proficient			
□ Scheduled Appointment □ Non-Scheduled Appointment □ No Show Date/Time:			
Name of Staff Completing Form:			

Section 1: Communication Assessment

□ Initial □ Reassessment □ Subsequent Appointment
Individual Communication Ability:
Nature, Length and Importance of Anticipated Communication Situation(s):
□ 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):

Header

Region/Circuit/Institution:	**Program:**	**Subsection:**	
□ Customer □ Companion **Name:**	**Date:**	**Time:**	**Case No.:**
□ Deaf □ Hard-of-Hearing □ Deaf and Low Vision or Blind □ Hard-of-Hearing and Low Vision or Blind **□ Deaf and Limited English Proficient □ Hard-of-Hearing and Limited English Proficient**			
□ Scheduled Appointment □ Non-Scheduled Appointment □ No Show Date/Time:			
Name of Staff Completing Form:			

Section 1: COMMUNICATION ASSESSMENT - Continued

□ Initial □ Reassessment □ Subsequent Appointment
Individual Communication Ability:
Nature, Length and Importance of Anticipated Communication Situation(s):
□ 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:

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 Remote Interpretive Service □ Large Print □ Assistance Filling Out Forms □ Video Relay Services □ Florida Relay □ Written Material □ CART □ Other:
Interpreter Service Status: □ Arrival Time: _____ □ Met Expectations of Client □ Met Expectations of Staff □ No Show □ Cancellations
Alternative Auxiliary Aid or Service Provided, including information on CD or Floppy Diskette, Audiotape, Braille, Large Print of Translated Materials:
Date and Time Provided:

SECTION 3: ADDITIONAL SERVICES REQUIRED:

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:

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

SECTION 5: DENIAL OF AUXILIARY AID/SERVICE:

Reason Requested Auxiliary Aid or Service Not Provided:	
Denial Determination made by Regional Director/Circuit Administrator/Hospital Administrator or Designee or the Contracted Client Services Provider or their Designee:	
Denial Date:	Denial Time:

COMMUNICATION PLAN FOR ONGOING SERVICES

A Communication plan is 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**.

COMMUNICATION PLAN FOR ONGOING SERVICES

Communication Plans are appropriate for:

- On-going investigations that will require repeated contacts,
- Customers receiving out-patient services for on-going treatment or counseling,
- Forensic facilities, **or**
- Other situations where you will have repeated contacts with customer or companion.

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN

Intake / Interview:

- During the **provision** of a Customer's rights, informed consent, or permission for treatment
- During the **determination** of eligibility for public benefits during the intake and review processes
- During the **initial** risk assessment, if follow-up is indicated.

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Medical:

- **Determination** of a Customer's medical, psychiatric, psychosocial, nutritional, and functional history or description of condition, ailment or injury
- **Determination** and explanation of a Customer's diagnosis or prognosis, and current condition;
- **Explanation** of procedures, tests, treatment options, or surgery
- **Explanation** of medications prescribed, such as dosage, instructions for how and when the medication is to be taken, possible side effects or food or drug interactions
- **Discussion** of treatment plans
- **Explanation** regarding follow-up treatments, therapies, test results, or recovery
- **During** visits by the Nurse

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Dental:

- **Explanation** of procedures, tests, treatment options, or surgery
- **Explanation** of x-rays
- **Instructions** on self maintenance, i.e., brushing, flossing, etc.

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Mental Health:

- **Provision** of psychological or psychiatric evaluations, group and individual therapy, counseling, and other therapeutic activities, including but not limited to grief counseling and crisis intervention
- **Provision** of discharge planning and discharge instructions

Safety and Security:

- **Communication** of relevant information prior to or as soon as possible after putting a person into restraints including but not limited to the purpose for using restraints and the conditions under which restraints will be removed
- **Communication** of emergency procedures, fire drills, etc.

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Programs:

- **Presentation** of educational classes concerning DCF programs and/or other information related to treatment and case management plans;

Off Campus trips or Recreational Activities:

- Shopping
- Theme Parks

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Legal:

- **Court proceedings**
- **Appeal Hearings**
- **Complaint and grievance process**
- **Investigation** by child protective services involving interviews, and home visits/inspections
- **Investigation** adult protective services involving interviews, and home visits/inspections

Food Service / Dietician:

- **Discussion** of food restrictions and preferences

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN - Continued

Type of Aid:
ASL Interpreter
Purpose of Aid:
GED Class – Instructions on preparation for upcoming test
Name and Title of Person Responsible for ensuring the Auxiliary Aid is provided:
John Q, Case Manager

Type of Aid:
Note Cards with checklist
Purpose of Aid:
Dietary – Menu selection
Name and Title of Person Responsible for ensuring the Auxiliary Aid is provided:
Jane Q, Dietician

Signature

Signature of person completing form:	Date:
Signature of Customer or Companion:	Date:

CUSTOMER OR COMPANION REQUEST*
FOR FREE COMMUNICATION ASSISTANCE

My name is _____

☐ I want a free interpreter. I need an interpreter who signs in:

☐ American Sign Language (ASL) or an interpreter who speaks.

☐ Language: _____ Dialect: _____

☐ I want another type of communication assistance (Check all desired assistance):

Assistive Listening Devices: ____ Large Print Materials: ____ Note takers: _____

TTY or Video Relay: ____ Assistance Filling out Forms: _____ Written Materials: _____ CART: _____

Other (Please tell us how we can help you): _____

_____

☐ I do not want a free interpreter or any other communication assistance. If I change my mind, I will tell you if I need assistance for my next visit. ***(Customer or Companion waiver of rights does not prevent the Department from getting its own interpreter or from providing assistance to facilitate communication and to make sure rights are not violated)***

☐ I do not want a free interpreter because_____.

☐ I choose _____ to act as my own interpreter. He/she is over the age of 18. ***It does not entitle my interpreter to act as my Authorized Representative. I also understand that the service agency may hire a qualified or certified interpreter to observe my own interpreter to ensure that communication is effective.***

CUSTOMER OR COMPANION REQUEST*
FOR FREE COMMUNICATION ASSISTANCE
OR WAIVER OF FREE COMMUNICATION ASSISTANCE

Customer or Companion Signature:	Date:
Customer or Companion's Printed Name:	
Interpreter's Signature:	Interpreter's Printed or Typed Name:
Witness:	Date:
Witness Printed Name:	

*This form shall be attached to the Customer Companion Communication Assessment and Auxiliary Aid and Service Record form and shall be maintained in the Customer's file.

Customer/Companion Feedback Form

Department of Children and Families
Customer/Companion Feedback Form
(To be completed by clients/customers who are Deaf or Hard-of-Hearing Only)

The Department of Children and Families is committed to providing excellent customer service. We value your opinion and request that you complete this short survey to assist us in evaluating and improving our services. While you are not required to respond, we thank you in advance for completing this survey. **The survey is ANONYMOUS; therefore, please do not provide your name or any other personal information UNLESS YOU WOULD LIKE TO BE CONTACTED.** Please complete the form and **submit it to the local office or mail to:** Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700.

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM PLEASE NOTIFY STAFF OR CONTACT THE OFFICE OF CIVIL RIGHTS AT (850) 487-1901 OR TDD (850) 922-9220

Please provide a response to the following:

1	Are you a: Client/Customer ☐ Companion ☐ who is deaf or hard-of-hearing?
2	Were you provided any assistive services and technologies? (Please check all that were provided.) ☐ Certified Interpreter ☐ Qualified Staff ☐ VRS ☐ Pocket Talker ☐ Motiva ☐ CART ☐ Other: _____
3	Were the assistive services and technologies effective? ☐ Yes ☐ No (If no, please explain.)
4	Were you denied assistive services and technologies? ☐ Yes (If yes, please complete #5) ☐ No a. What was requested? _____ b. What was provided? _____
5	If you answered yes to #4, please provide the reason you were given for denial of the requested assistive services and technologies?
6	Did you agree with the agency's decision given for the denial of the requested assistive services and technologies? If no, why?
7	The request for assistive services and technologies was made: ☐ Before the Appointment

AUXILIARY AID SERVICE RECORD MONTHLY SUMMARY REPORT:

Region/Circuit/Institution/Contracted Client Services Provider: **Contract No.**	**Reporting Period:**	
Name of Program & Address:	**Subsection:**	
Single-Point-of-Contact: **Name of Person Completing Form:**	**Telephone:** **Telephone:**	**Date:**
SECTION I. CUSTOMERS		
SECTION II. COMPANIONS		
SECTION III. AUXILIARY AIDS AND SERVICES PROVIDED **(This section is completed by Contracted Client Services Providers only)**		
SECTION IV. AUXILIARY AIDS AND SERVICES PROVIDED **(This section is completed by Department of Children and Families staff only)**		
SECTION V. COMMUNICATION PLANS **(This section is completed for Institutions and Residential Settings only)**		
SECTION VI. OUTSIDE AGENCY REFERRALS		
SECTION VII. COMMENTS/OBSERVATIONS		
All services were provided in accordance with the Department's (DCF) policies and procedures, Title VI of the Civil Rights Act of 1964, as amended, the U.S. HHS Settlement Agreement (dated January 26, 2010), and other applicable federal and state laws.		

ADDITIONAL DOCUMENTS TO BE SUBMITTED WITH THE MONTHLY SUMMARY REPORT.

1. The **Customer or Companion Communication Assessment Form** in the following instances shall be attached to the Monthly Summary Report.

   - When the requested auxiliary aid or service **was not what was provided**.
   - When the auxiliary aid or service **did not meet the expectation** of the customer, companion or staff
   - When the communication was **not found to be effective**
   - When the requested auxiliary aid or service **was denied**.
   - When requested by the Department or HHS.

2. The **Request For Free Communication Assistance or Waiver of Free Communication Assistance Form** that corresponds with the above accompanying form.

REPORTING DATES FOR MONTHLY SUMMARY REPORT:

- The Department and its Contracted Client Services Providers will begin using all of the revised forms mentioned in this presentation on July 1, 2011.

- The reporting period will follow the guidelines listed below:

  - Reporting period will cover the 1st through the 30th or the 31st of each month.

  - DCF Single-Points-of-Contact reports are due to the Civil Rights Officer by the 10th of each month.

AUXILIARY AID SERVICE RECORD MONTHLY SUMMARY REPORT:

- Contracted Client Services Providers Single-Points-of-Contact reports are due to the Contract Manager by the 5th business day of each month, **or** as agreed upon between the Contract Manager and the provider.

- Contract Managers will submit reports to the Civil Rights Officers by the 15th of each month.

- Civil Rights Officers will submit reports to Headquarters Office of Civil Rights by the 20th of each month.

AUXILIARY AID SERVICE RECORD MONTHLY SUMMARY REPORT - CONTINUED

REPORTING DATES AND GUIDELINES - CONTINUED:

- Headquarters Office of Civil Rights will submit reports to the U.S. Department of Health and Human Services or the Independent Consultant by the 25th of each month.

Note: If the due date falls on a weekend or holiday, the report will be due the next business day.

COMPLIANCE IS NOT AN OPTION

- Remember, **Compliance is not an Option.**
- Our mission is to Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency.
- We **must** be in compliance with these guidelines and instructions to ensure that we are serving the people in the State of Florida in a fair and non-discriminatory manner.
- As always, please contact your Single-Point-of-Contact or your ADA/Section 504 Coordinator (Civil Rights Officer) or the Office of Civil Rights for assistance.
- We will leave the webinar lines open to allow you additional time to submit your questions. All questions and responses will be posted on our HR website beginning **July 12th**.

Thank you

DCF'S ADA/SECTION 504 COORDINATORS

- **Headquarters/Northwood Centre** - Pamela Thornton (850) 717-4567
- **Florida State Hospital** – Aldrin Sanders (850) 717-4566
- **Northwest Region** – Juan Cox (850) 717-4565
- **Northeast Region** – Richard Valentine (904) 723-2097
- **Suncoast Region** – Sharon Pimley-Fong (813) 558-5656
- **Central Region** – Pamela Phillips (407) 317-7552
- **Southeast Region** - Caroline Johnson (561) 837-5538
- **Southern Region** – Roosevelt Johnson (305) 377-5219