Rhode Island Department of Education

Child Outreach Screening

Dear Families,

It is time to schedule your child's annual Child Outreach Screening. This screening is free and recommended for every child, every year at the ages of three, four, and five years. Screening can usually be completed within 45 minutes.

Child Outreach Screening provides important information about your child's growth and development. It can help you understand how your child is progressing in the areas of vision, hearing, speech/language, social/emotional, and general development. Screening can also assist in identifying children who may need further assessment and intervention at an early age in order to prevent the occurrence of more significant problems later.

The Rhode Island Department of Education and your local school district are your partners in ensuring the success of your child. We want to make sure all children are off to a great start before they enter kindergarten! Please contact your local Child Outreach Office to make an appointment.

You may also learn more about Child Outreach by visiting https://www.ride.ri.gov/InstructionAssessment/EarlyChildhoodEducation/EarlyChildhoodSpecialEducation/ChildOutreachScreening.aspx.

If you no longer reside in _____ ~~or~~ the State of Rhode Island, please contact us so that we can update our records.

Sincerely,

Kim Smith

Child Outreach Coordinator

Child Outreach Address: Wilbur Mc Mahon School
28 Commons
Little Compton, RI

Child Outreach Phone: _____

Child Outreach Email: Ksmith@lcsd.k12.ri.us

* screenings take place on Wednesdays between 9 and 2.

Mark Dufresne
Student Support Services Director

Dr. Laurie Dias-Mitchell
Superintendent

CHILD OUTREACH SCREENING - PARENT CONSENT FORM

Child's Name _____ D.O.B._____

Child Outreach is a developmental screening system designed to screen all 3–5-year-olds annually prior to kindergarten entry. Children are screened in the areas of vision, hearing, general development, speech/language, and social/emotional development. The general development and social-emotional screens may be questionnaires completed by the parent/guardian and/or foster parent. If the child is in school and additional information is needed, the child's teacher will also complete the questionnaires. Child Outreach is an important first step in the identification of children who may require further evaluation or intervention. Accordingly, public school systems within the state of Rhode Island conduct Child Outreach screening programs. Parents, guardians, and when applicable, foster parents and DCYF Caseworkers, will receive a summary of Child Outreach screening results. All personal information and screening results collected during the screening process are treated in the strictest confidence.

The Department of Education is responsible for the general supervision of the Child Outreach Screening Program. The Department of Health maintains the KIDSNET data system, which hosts Child Outreach data on behalf of Rhode Island public school systems. KIDSNET, a secure database, also includes children's vaccinations, lead screenings, preventive health services, and other developmental screenings. The information in KIDSNET can be used to coordinate care, assure that preventive health services are provided, and identify children who may need medical and/or developmental support. No personal information or screening results however will be released without written consent to anyone other than personnel in the public school district in which your child resides and the Rhode Island Department of Elementary and Secondary Education, the Rhode Island Department of Health for regulatory purposes, and when applicable the Department of Children, Youth and Family for children in foster care.

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1. I have read the above statements and give permission for my child to be screened by a Child Outreach program and for the results and recommendations of the screening, including any necessary special education referral and eligibility determination, to be included in the Child Outreach database within KIDSNET.

Parent/Guardian Signature _____ Date _____

2. I have read the above statements and give Child Outreach and the Department of Health/KIDSNET permission to share the results and recommendations of my child's screening, including any necessary special education referral and eligibility determination, with his/her **primary care provider (doctor)** for the purposes of coordinating care, assuring the provision of preventative health services and identifying children who may need medical and/or developmental support.

Parent/Guardian Signature _____ Date _____

Doctor's Name:_____
Office or Practice Name:_____
Phone Number:_____
Address:_____

3. I have read the above statements and give Child Outreach and the Department of Health/KIDSNET permission to share the results and recommendations of my child's screening, including any necessary special education referral and eligibility determination, with his/her **preschool/childcare program** for the purposes of educational planning.

Parent/Guardian Signature _____ Date _____

Name of Preschool/Childcare Program:_____Phone Number:_____

Consent in effect from September 2024 - September 2025

You have the right to revoke consent at any time by contacting your local school district. You also have the right to inspect your child's education records and to request that KIDSNET correct any information that you believe is inaccurate. The RI Special Education Procedural Safeguards Notice Model Form, which explains parents' rights under Part B of the Individuals with Disabilities Education Act, can be found at https://www.lcsd.k12.ri.us/sss. If you have any questions about parental rights, including consent to screen, please contact RIDE's Special Education Call Center at 401-222-8999.

Mark Dufresne
Student Support Services Director

Dr. Laurie Dias-Mitchell
Superintendent

CONSENT TO ACCESS MEDICAID FUNDS

Student:	**DOB:**	**Grade:**
Home School:	**Current School:**	
Date of Meeting:	**Case Manager:**	

Dear Parent/Guardian:

The Little Compton School Department Student Support Services (LCSDSSS) provides special education and related services as a free and appropriate public education (FAPE), at no cost to the parents, in the least restrictive environment (LRE). The LCSDSSS can seek reimbursement through Medicaid for some special education services and **Child Outreach screenings** for students who are eligible for Medicaid benefits.. Section 300.154 of the Rhode Island Board of Education's Regulations Governing the Education of Children with Disabilities Education requires that the LCSDSSS receive your written informed consent in order to seek Medicaid reimbursement for certain special education services. Before you give or deny consent, please read the following:

Parental Consent: Please **check all of the following** (this is informed consent):

- ☐ I understand that giving my consent to the district to access Medicaid reimbursement for services provided to my child will not impact my ability to access these services for my child outside the school setting.
- ☐ I understand this consent does not include consent for assistive technology devices. The district needs a separate consent form when accessing reimbursement for any assistive technology device.
- ☐ I understand that services in my child's IEP must be provided at no cost to me, whether or not I give consent to bill Medicaid. [If I refuse consent or if I revoke (withdraw) this consent, the school district is still responsible to provide special education and any related services identified for my child through the special education eligibility processes and these services will be provided at no cost to me. This includes no costs for co-pays, deductibles, loss of eligibility or impact on lifetime benefits.]
- ☐ I understand that my consent is voluntary and I may revoke (withdraw) my consent in writing at any time after it is given. If I revoke (withdraw) my consent, the school department will no longer bill Medicaid from the date the written revocation (withdrawal) of consent is received by the district.
- ☐ I understand that the district follows both the Health Insurance Portability and Accountability Act (HIPAA - the federal health privacy act) and the Family Educational Rights and Privacy Act (FERPA - the federal education privacy act) requirements to protect my confidential information and that Medicaid funds received by the district directly support education in our district.

Permission **given or denied (please check one)**:

- ☐ I **give** permission to the district to share information about my child with the state Medicaid Agency, its fiscal agent, and the district's Medicaid billing agent. The information shared may include my child's name, date of birth, address, primary special education disability, Medical Assistance Identification number (MID), and the type and amount of residential program treatment, child outreach screening, transportation, and services and/or evaluations provided by physical therapists, occupational therapists, speech, hearing and language therapists, licensed psychologists, social workers and nurses.
- ☐ I **do not give** permission to the district to share information about my child in order to seek Medicaid reimbursement for services provided to my child.

Parent/Guardian Signature: _____ Date:_____

APPENDIX E

RI CHILD OUTREACH SCREENING
FAMILY HISTORY QUESTIONNAIRE

Child's Last Name:	Middle Initial:	First Name:	Date of Birth:

<u>#1- Parent / Guardian/ Foster Parent</u> (Please circle) Name:	<u>#2- Parent / Guardian/ Foster Parent</u> (Please circle) Name: ____ Check here if you'd like additional results sent to this parent/guardian.
Address:	Address:
Mailing Address (if different):	Mailing Address (if different):
Primary Phone Number:	Primary Phone Number:
Alternate Phone Number:	Alternate Phone Number:
Email Address:	Email Address:
Best way to contact family: *phone/ email* (circle one)	Best way to contact family: *phone/ email* (circle one)
Other children living in household: Name: _____ D.O.B.: _____ Name: _____ D.O.B.: _____ Name: _____ D.O.B.: _____	Other children living in household: Name: _____ D.O.B.: _____ Name: _____ D.O.B.: _____ Name: _____ D.O.B.: _____
Who does the child live with?	Child's Primary Language:

Has your child's hearing been tested? Yes ___ N o ___ When/by whom: _____

Has your child had 3 or more ear infections? Yes _____ No _____ Does your child have tubes? Yes _____ No _____

Do you have concerns about your child's hearing? Yes _____ No _____ List concerns: _____

Has your child's vision been tested? Yes _____ No _____ When/by whom: _____

Do you have concerns about your child's vision? Yes _____ No _____ List concerns: _____

Does your child wear glasses? Yes _____ No _____

Additional Relevant Health Information:

RI CHILD OUTREACH SCREENING

FAMILY HISTORY QUESTIONNAIRE • PAGE 2

Does your child currently receive Special Education services ? Yes _____ No _____
Did your child receive Early Intervention services? Yes _____ No _____
Do you have any concerns with your child's development? (Please explain)
What things are difficult for your child?
Does your child currently attend preschool? Yes _____ No _____ Name of Preschool: _____ Times attending: Monday _____ AM _____ PM *(please check all that apply)* Tuesday _____ AM _____ PM Wednesday _____ AM _____ PM Thursday _____ AM _____ PM
Please list anything else you would like us to know about your child's developmental history or family.
Name of person completing this form: _____ Relationship to child: _____
THANK YOU

RI Child Outreach Screening does not discriminate on the basis of age, sex, sexual orientation, race, religion, national origin, color or disability in accordance with applicable state laws and regulations.

APPENDIX H

PRESCHOOL LANGUAGE SURVEY

Child's Name: _____ Child's Birthplace: _____

Child's Age: _____ Child's Age When First Exposed to English: _____

Does the child talk? ☐ No ☐ Yes, Single Words ☐ Yes, Puts 2-3 Words Together ☐ Yes, Sentences

Family's Country of Origin: _____ Number of Years Family Has Lived in the USA _____

If English is not the family's first language, do they prefer verbal or written communication?

☐ No preference ☐ Verbal (phone/in person) ☐ Written (letters/forms)

Form Completed By: _____ Relationship to Child: _____

HOME LANGUAGE INFORMATION:

1. What language did the child first learn to speak? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

2. What language does the child speak most often? ☐ English ☐ Spanish ☐ Other: _____

3. What language is spoken to the child most often? ☐ English ☐ Spanish ☐ Other: _____

4. Does anyone else care for the child during the week (*ex. grandparents, babysitter, etc.*)? ☐ No ☐ Yes

If so, what language does he/she speak most often? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

5. What language is used most often when parents speak to each other? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

6. What language(s) does the child use most often when speaking with the following people?

Parents: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Siblings: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Relatives: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Friends ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

LANGUAGE EXPOSURE

7. Does/Did the child attend school or receive Early Intervention?

☐ No ☐ Yes- Head Start ☐ Yes- Preschool ☐ Yes- EI

Name of school or EI: _____

What language is/was used? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

8. What language is the child exposed to or uses most often during the following activities?

Books/Storytelling: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

TV/Radio: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

Computer/Video games: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

Play: ☐ English ☐ Spanish ☐ Both ☐ Other: _____