CPI must complete ALL sections. Submit forms to Jenean

CUSTOMER OR COMPANION COMMUNICATION ASSESSMENT AND AUXILIARY AID/SERVICE RECORD

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

Region/Circuit/Institution:	Program:	Subsection:
SE/Circuit 15	Family Safety	Child Investions

☐ Customer ☐ Companion Name: Client's Name [redacted] Date of Contact: Time: Case No.: Complete Sections

☐ Deaf ☐ Hard-of-Hearing ☐ Deaf & Low Vision or Blind ☐ Hard-of-Hearing & Low Vision or Blind
☐ Deaf & Limited English Proficient ☐ Hard-of-Hearing & Limited English Proficient Select One

☐ Scheduled Appointment ☐ Non-Scheduled Appointment ☐ No Show Date/Time: Select One

Name of Staff Completing Form: Name of CPI

Section 1: Communication Assessment

☐ Initial ☐ Reassessment ☐ Subsequent Appointment Select One

Individual Communication Ability:
I.E. 1)client uses hearing aids 2)client can hear when spoken to loudly 3)client is deaf, needs intrepreter

Nature, Length and Importance of Anticipated Communication Situation(s):
I.E. face to face interview was completed

☐ 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): List all parties involved: CPI name, client name, intrepreter name

Individual Health Status for Those Seeking Health Services:
I.E. 1)stable 2)lacks capcity 3)N/A

Section 2: Auxiliary Aid/Service Requested and Provided

Type of Auxiliary Aid/Service Requested: Date Requested Time Requested:
I.E. 1) intrepreter 2) pocket talker

Nature of Auxiliary Aid/Service Provided: Select service provided, if none put N/A

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: pocket talker if they used one

Interpreter Service Status: Arrival Time: ____ ☐ Met Expectations of Client ☐ Met Expectations of Staff
☐ No Show ☐ Cancellation: N/A if interpreter is not used

Alternative Auxiliary Aid or Service Provided, including information on CD or floppy disk, audiotape, braille, large print, or translated materials:
N/A if no devices were used

Date and Time Provided: N/A if no devices were used

Section 3: Additional Services Required

Was communication effective? ☐ Yes ☐ No If not, please explain why communication was not effective.
If communication was not effective CPI MUST state why in this space.

What action(s) was taken to ensure effective communication?
I.E. 1) client has hearing aids 2) CPI spoke loud enough to be heard 3) client used pocket talker/intrepreter

Section 4: Referral Agency Notification

Name of Referral Agency:
N/A if no referral agency is used

Date of Referral:	Information Provided Regarding Auxiliary Aid or Service Need(s):
	N/A if no aid or service is needed

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:	
N/A	
Name of Regional Managing Director (or designee) or Hospital Administrator (or designee) or the Contracted Client Services Provider Administrator (or designee) Making Denial Determination:	
N/A	
Denial Date:	Denial Time:
N/A	N/A

SAMPLE

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.

- ☐ Intake/Interview: check off this box for face to face interviews
- ☐ Medical:
- ☐ Dental:
- ☐ Mental Health:
- ☐ Safety and Security:
- ☐ Programs:
- ☐ Off Campus Trips:
- ☐ Legal:
- ☐ Food Service/Dietician:
- ☐ Other:

Signature of Person Completing Form:	Date:
Name of CPI	
Signature of Customer or Companion:	Date:
If client lacks capacity, indicate by writing client lacks capacity	

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 Companion 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.

CUSTOMERS OR COMPANIONS WHO ARE DEAF OR HARD OF HEARING

REQUEST FOR FREE COMMUNICATION ASSISTANCE

The Florida Department of Children and Families and its Contracted Client Services Providers are required to provide **FREE Interpreters, other communication assistance** for persons who are deaf or hard of hearing. Please tell us about your communication needs.

My name is ___Client Name_____

Select One

☐ 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)***

WAIVER OF FREE COMMUNICATION ASSISTANCE

☐ I do not want a free Interpreter because _____.

☐ I choose _____ to act as my own Interpreter. He/she is over the age of 18. ***This 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 Signature:	Date:
Customer or Companion's Printed Name: If client lacks capacity, indicate that by writing client lacks capacity in this space	
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.**

* This form stays with the client to mail in.

CUSTOMER OR COMPANION FEEDBACK FORM

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. You may remain anonymous, unless you wish to be contacted. When the form is completed, please mail it 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 completing this form, please contact the Office of Civil Rights at (850) 487-1901 or TDD (850) 922-9220.

DCF Program Office or Agency Name :_____

Location:_____

1. Were you offered any services to help you communicate? ☐Yes ☐No
2. Did you ask for any services to help you communicate? ☐Yes ☐No
3. If yes, what services to help you communicate did you receive? _____
4. Did you receive the services to help you communicate you asked for? ☐Yes ☐No
5. Did you understand completely? ☐Yes ☐No
6. Were you denied any services to help you communicate? ☐Yes ☐No
7. Were you satisfied with the services to help you communicate? ☐Yes ☐No
8. If not, why?_____
   _____
9. Did you know that these services to help you communicate were at no cost? ☐Yes ☐No
10. Did staff treat you with respect? ☐Yes ☐No

Can we contact you? Phone number or email:_____

Comments:

Please complete and return to: **Office of Civil Rights**
1317 Winewood Boulevard
Building 1, Room 110
Tallahassee, Florida 32399

← Client mails form to this address