

**Coordinated Family Support (CFS)  
Referral and Service Need Assessment**

**Consumer Name:** \_\_\_\_\_

**UCI:** \_\_\_\_\_

Confidential Consumer Information  
See California Welfare and Institutions  
Code Sections 4514 and 5328

**Service Coordinator:** \_\_\_\_\_

**Date:** \_\_\_\_\_

CFS is for adults with developmental disabilities who live in the family home. CFS is designed to facilitate equitable access to services and supports. CFS services will be tailored, individualized, and flexible to meet the changing needs and preferences of the individual being served along with their family/caregiver. Supports will be provided in a manner that is respectful of the culture, ethnicity and linguistic preferences of the individual and their family. A CFS Plan of Action shall not replace or duplicate any regional center service coordination, generic service or other regional center funded service that the consumer and their family are receiving.

**Directions:** **Step 1:** The Service Coordinator will complete Section 1 of the Referral and Service Need Assessment form prior to meeting with the IPP Team. **Step 2:** The Service Coordinator and the IPP Team will complete Section 2 of the Referral and Service Need Assessment form. This requires determining if a CFS Plan of Action is needed and marking 'Yes' or 'No' for each item. **Step 3:** If a Plan of Action is needed, the IPP Team is to complete the corresponding 'Current Situation' field. Once the form is completed, it will be used as the referral to a CFS provider. **Step 4:** The CFS provider will meet with the individual and their family to develop a proposed CFS Plan of Action. The completed Referral and Service Need Assessment form, with the Plan of Action portion completed will be returned to the Service Coordinator for service authorization consideration. **Step 5:** If the service is authorized, the approved Referral and Service Need Assessment form is returned to the CFS provider, along with the Standardized Quarterly Reporting Tool, and the consumer/family is provided the Initial Satisfaction Survey.

**Section 1 (to be completed by Regional Center Service Coordinator):**

1. The individual is 18 years of age or older.
2. The individual is currently living with family.  
**If answer to #1 or #2 is No, do not proceed – the consumer is not eligible for CFS.**
3. Relationship of primary family member/caregiver:
4. Age of primary family member/caregiver:
5. Consumer's preferred spoken/expressive language:

- 6. Consumer's preferred written/receptive language:
- 7. Family/caregiver's preferred spoken/expressive language:
- 8. Family/caregiver's preferred written/receptive language:
- 9. Communication device(s) or assistive technology used by consumer or family:
- 10. Are there any known cultural considerations that the CFS provider should be aware of?

- 11. Primary reason for a CFS referral:
- 12. Date of IPP addendum:

**Section 2** - With the IPP Team, the Service Coordinator will indicate whether a CFS Plan of Action is needed ('Yes' or 'No'). For each item in which a CFS Plan of Action is needed, include a description of the individual's current situation. If no CFS Plan of Action is needed, do not provide information about the current situation. The CFS Plan of Action field will be completed by the CFS provider.

<p><b>1. Identifying and providing supports necessary to successfully reside in the family home</b></p> <p>Is a CFS Plan of Action Needed? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Current Situation – to be completed by the IPP Team (<i>Consider the following: the structure and routines of the family, the residence/housing needs, the plan if the family is unable to care for the consumer, the backup plan for identified support/service needs, if the consumer requires overnight supports, if there is behavioral health needs or Court Involvement, if the physical dwelling is fully accessible, if the consumer has a disaster plan, or if consumer is transitioning out of public school what, if any, the potential impact is to the family</i>) -</p>
<p>CFS Plan of Action (<i>Person-centered/family-centered, specific and measurable</i>):</p>

Proposed Number of Monthly Hours to Implement #1 Plan of Action: \_\_\_\_\_

**2. Providing assistance and training for the consumer and their family in navigating comprehensive services and supports that are tailored to meet their unique needs, including creating pathways to overcoming barriers to accessing generic and other resources**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: generic services (like SSI, IHSS, Cal-Fresh, etc.) and other services the consumer currently receives, how successful the consumer and family are in obtaining and using resources and voluntary supports, how the consumer and family deal with and respond to governmental entities (like Social Security), including the completion of necessary paperwork to obtain and maintain services and benefits, the use of communication aides, service animals or the like)*

CFS Plan of Action *(Person-centered/family-centered, specific and measurable)*:

Proposed Number of Monthly Hours to Implement #2 Plan of Action: \_\_\_\_\_

**3. Providing additional information or resources on the consumer's diagnosis and identified supports**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: the families need for more information about the consumer's diagnosis, what may come with different stages of life, and/or identifying resources/supports such as support groups, family advocacy groups, whether this consumer and family are new to the system serving people with developmental disabilities or if this might be a new living situation).*

CFS Plan of Action *(Person-centered/family-centered, specific and measurable):*

Proposed Number of Monthly Hours to Implement #3 Plan of Action: \_\_\_\_\_

**4. Coordinating consistency in training across providers specific to the needs of the consumer and their family**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: if there is consistency in training, in both education and information, about the consumer and family needs so that individuals working with them are prepared)*

CFS Plan of Action (*Person-centered/family-centered, specific and measurable*):

Proposed Number of Monthly Hours to Implement #4 Plan of Action: \_\_\_\_\_

**5. Assisting with scheduling of service delivery including medical and other appointments**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: (*Consider the following: how the consumer's medical and dental services are scheduled, if there is assistance needed for communication/interpretation for appointments and how that is delivered, if they are able to independently navigate how to find good health care and their insurance plan, and understand what the healthcare professional like doctor or dentist is telling them*)

CFS Plan of Action (*Person-centered/family-centered, specific and measurable*):

Proposed Number of Monthly Hours to Implement #5 Plan of Action: \_\_\_\_\_

**6. Identifying transportation options or services**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: If the consumer identifies and utilizes transportation successfully whether they drive independently, have a desire to obtain their driver's license, safely and successfully use public or private (like Uber or Lyft, etc) transportation (with or without assistance), or other forms of transportation like riding their bike)*

CFS Plan of Action *(Person-centered/family-centered, specific and measurable):*

Proposed Number of Monthly Hours to Implement #6 Plan of Action: \_\_\_\_\_

**7. Identifying backup providers/supports and providing those backup supports when the plan fails**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: the plan in place for backup providers for any necessary services and supports for the consumer and their family)*

CFS Plan of Action (*Person-centered/family-centered, specific and measurable*):

Proposed Number of Monthly Hours to Implement #7 Plan of Action: \_\_\_\_\_

**8. Providing futures planning for the consumer, including those living with aging caregivers**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: (*Consider the following: if the consumer and family have developed a plan for the future on what their wish would be if they change where they live and who they live with, how it will be paid for, whether a CalABLE account or Special Needs Trust has been developed, how supported decision making is conducted, whether there is a need for an advanced healthcare directive, etc.*)

CFS Plan of Action (*Person-centered/family-centered, specific and measurable*):

Proposed Number of Monthly Hours to Implement #8 Plan of Action: \_\_\_\_\_

**9. Providing training to the consumer which maximizes their independence**

Is a CFS Plan of Action Needed? Yes  No

Current Situation: *(Consider the following: whether the consumer knows how to self-advocate and is connected to a self-advocacy group, preparing to move into a home of their own, building positive relationships, going to college or getting employment, and participating in the community or whether Independent Living Services would be appropriate to address the consumers desire to increase independence in meal planning, preparation, and cleanup; household duties or managing finances)*

CFS Plan of Action *(Person-centered/family-centered, specific and measurable):*

Proposed Number of Monthly Hours to Implement #9 Plan of Action: \_\_\_\_\_

**10. Other - need that has been identified within the scope of the service, but not identified in Items #1-9 above.**

Is a CFS Plan of Action Needed? Yes  No

Current Situation:



CFS Plan of Action ( <i>Person-centered/family-centered, specific and measurable</i> ):
Proposed Number of Monthly Hours to Implement #10 Plan of Action: _____

**Total Number of Proposed Monthly Hours for Items #1-10:** \_\_\_\_\_

**Section 3: (to be completed by Service Coordinator)**

Date of Referral to CFS Provider:	
CFS Provider Name:	
CFS Provider Point of Contact (Staff name):	
CFS Provider Phone number:	
The following documents are included with this referral: <ul style="list-style-type: none"> <li><input type="checkbox"/> CDER</li> <li><input type="checkbox"/> IPP and if available Person-Centered Plan</li> <li><input type="checkbox"/> Most recent regional center report (i.e. Quarterly or Annual)</li> </ul>	

<input type="checkbox"/> Any pertinent assessments (i.e., behavioral, medical, etc)	
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**Section 4: (To be completed by the CFS Provider)** The CFS provider will meet with the individual and their family to develop a proposed CFS Plan of Action for each area that the IPP Team indicated a CFS Plan of Action is needed. Each CFS Plan of Action will be described in Section 2 with a corresponding proposed number of hours per month. The CFS provider will return the completed Referral and Service Need Assessment form to the Service Coordinator for service authorization consideration.

<b>To Be Completed by CFS Provider:</b>	
CFS Assessment Completed by (Staff Name):	
CFS Assessment Completed on (Date):	
CFS Assessment returned to Service Coordinator (Date):	
<b>To Be Completed by Regional Center Service Coordinator:</b>	
Service Authorization Request	
Date Service of Authorization or Denial+:	
Date service begins:	
Number of Hours Authorized for CFS:	
Date Initial Satisfaction Survey provided to Consumer:	