



# 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.**

<b>Region/Circuit/Institution:</b>	<b>Program:</b>	<b>Subsection:</b>	
<input type="checkbox"/> <b>Customer</b> <input type="checkbox"/> <b>Companion</b> <b>Name:</b>	<b>Date:</b>	<b>Time:</b>	<b>Case No.:</b>
<input type="checkbox"/> <b>Deaf</b> <input type="checkbox"/> <b>Hard-of-Hearing</b> <input type="checkbox"/> <b>Deaf and Low Vision or Blind</b> <input type="checkbox"/> <b>Hard-of-Hearing and Low Vision and Blind</b> <input type="checkbox"/> <b>Deaf and Limited English Proficient</b> <input type="checkbox"/> <b>Hard-of-Hearing and Limited English Proficient</b>			
<input type="checkbox"/> <b>Scheduled Appointment</b> <input type="checkbox"/> <b>Non-Scheduled Appointment</b> <input type="checkbox"/> <b>No Show</b> <b>Date/Time:</b>			
<b>Name of Staff Completing Form:</b>			

## Section 1: Communication Assessment

<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Reassessment</b> <input type="checkbox"/> <b>Subsequent Appointment</b>
<b>Individual Communication Ability:</b>
<b>Nature, Length and Importance of Anticipated Communication Situation(s):</b>
<input type="checkbox"/> <b>Communication Plan for Multiple or Long-Term Visits Completed</b> <input type="checkbox"/> <b>Not Applicable</b>
<input type="checkbox"/> <b>Aid-Essential Communication Situation</b> <input type="checkbox"/> <b>Non-Aid Essential Communication Situation</b>
<b>Number of Person(s) Involved with Communication:</b>
<b>Name(s):</b>
<b>Individual Health Status for Those Seeking Health Services:</b>

## Section 2: Auxiliary Aid/Service Requested and Provided

<b>Type of Auxiliary Aid/Service Requested:</b>	
<b>Date Requested:</b>	<b>Time Requested:</b>
<b>Nature of Auxiliary Aid/Service Provided:</b>	
<b>Sign Language Interpreter:</b> <input type="checkbox"/> <b>Certified Interpreter</b> <input type="checkbox"/> <b>Qualified Staff</b> <input type="checkbox"/> <b>Video Remote Interpretive Service</b> <input type="checkbox"/> <b>Large Print</b> <input type="checkbox"/> <b>Assistance Filling Out Forms</b> <input type="checkbox"/> <b>Video Relay Services</b> <input type="checkbox"/> <b>Florida Relay</b> <input type="checkbox"/> <b>Written Material</b> <input type="checkbox"/> <b>CART</b> <input type="checkbox"/> <b>Other:</b>	
<b>Interpreter Service Status:</b> <input type="checkbox"/> <b>Arrival Time: _____</b> <input type="checkbox"/> <b>Met Expectations of Client</b> <input type="checkbox"/> <b>Met Expectations of Staff</b> <input type="checkbox"/> <b>No Show</b> <input type="checkbox"/> <b>Cancellations</b>	
<b>Alternative Auxiliary Aid or Service Provided, including information on CD or Floppy Diskette, Audiotape, Braille, Large Print of Translated Materials:</b>	
<b>Date and Time Provided:</b>	

## 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 by Department\*

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:

**\*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 Regional Director/Circuit Administrator/Hospital Administrator or their Designee or the Contracted Client Services Provider or their Designee.**

#### 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 Customers or Companions, 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 incorporate into 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.**

☐ Intake/Interview:

☐ Medical:

☐ Dental:

☐ Mental Health:

☐ Safety and Security:

☐ Programs:

☐ Off Campus trips:

☐ Legal:

☐ Food Service / Dietician

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

**\*This form shall be maintained in the customer's file.**

## **INSTRUCTIONS FOR CUSTOMER/COMPANION COMMUNICATION ASSESSMENT AND AUXILIARY AID AND SERVICE RECORD**

The purpose of the Customer Companion Communication Assessment and Auxiliary Aid and Service Record is to facilitate the collection and coordination of auxiliary aids and services provided to Customers or Companions who are deaf or hard-of-hearing. It is recommended that the person or persons that have been designated to complete the form become familiar with its contents so we can readily identify the needs of our Customers Companions.

### **HEADER:**

The form must be completed for each Service Date. All information must be legible. All requested information must be included on the form.

**Indicate your Region/Circuit/Institution:** For Example:

- If you work in Pensacola, then you would enter: Northwest/Circuit 1;
- If you work at Florida State Hospital, then you will enter: Northwest/Circuit 2/FSH. **Or**
- If you are a provider in the Northwest Region you will enter: Northwest Region/Circuit Number/Provider name

**Program:**

- For example: Family Safety, ACCESS, Mental Health, and so forth.

**Subsection:**

- For example: If your Program is ACCESS, then your Subsection may be – Call Center, Food Stamps, Medicaid, and so forth.

**You must identify if the individual being served is a Customer or a Companion.**

- A **Customer** is any individual seeking or receiving services from the Department or any of its' Contracted Service Providers.
- A **Companion** is any individual who is deaf and hard-of-hearing and communicates with the Department or any of its' Contracted Service Providers on the behalf of the Customer.

**Include their name, date and time of contact, and their case number or other identifier:**

- Exclude social security number, date of birth, driver's license, etc.

**Indicate if the individual is: Check one box only.**

- Deaf or Hard-of-Hearing: This is a person with a low or permanent hearing loss requiring the use of auxiliary aids or services.
- Deaf and Low Vision or Blind: This is a person with any loss of vision.
- Hard-of-Hearing and Low Vision or Blind, as described above.
- Deaf and Limited English Proficient: This is a person who does not speak English, or has the limited ability to read, speak, write, or understand English.
- Hard-of-Hearing and Limited English Proficient, as described above.

**Identify if it is a scheduled appointment or if it is a non-scheduled appointment:**

- **Scheduled Appointment** – Must have a certified interpreter available at the time of the schedule appointment. If interpreter fails to appear, staff shall take whatever additional actions are necessary to make a certified interpreter available to the Customer or Companion as soon as possible, but in no case later than **two (2) hours** after the scheduled appointment.
- **Non-Scheduled Appointment** – In emergency situations an interpreter shall be made available as soon as possible, but in no case later than two (2) hours from the time the Customer or Companion or staff requests an interpreter, whichever is earlier. If the situation is not an emergency, staff shall offer to schedule an

appointment (and provide an interpreter when necessary for effective communication) as convenient to the Customer or Companion, **at least by the next business day.**

**It is very important to include the name of the staff member completing this assessment.**

- Please print or ensure your handwriting is legible.

#### **SECTION 1: COMMUNICATION ASSESSMENT:**

##### **Initial assessment:**

- Check the box if this is an initial assessment.
- Initial assessments are done upon first contact with the customer or companion.

##### **Reassessment:**

- Check the box if this is a reassessment.
- In the event communication is not effective, or if the nature of the communication changes significantly after the initial assessment, staff shall conduct a reassessment to determine which appropriate auxiliary aid or service is necessary.
- This shall be accomplished, when possible, in consultation with the Customer or Companion.

**Subsequent Appointment:** Check the appropriate box.

##### **Individual Communication Ability:**

- Always consult with the Customer or Companion when possible to determine which appropriate auxiliary aids and services are needed to ensure effective communication.

##### **Nature, Length, and Importance of Anticipated Communication Situation (s):**

- The assessment shall take into account the nature, length, and importance of the communication at issue and anticipated communication situations.
- This section should be completed with much detail, as this will assist in determining whether the communication is aid essential or non-aid essential.
- Consult with the customer or companion where possible to determine what type of auxiliary aid or service is needed to ensure effective communication.
- Use this information to assist in determining whether a communication plan is necessary.
- You may attach additional sheets detailing this information.

##### **Individual Health Status or Medical Concerns:**

- Do not use electronic devices or equipment that may interfere with medical or monitoring equipment or which may otherwise constitute a threat to any Customer's medical condition.
- You shall provide alternative means to effective communication and document this information in the medical chart or case file.



#### **Complete a Communication Plan for foreseeable multiple or long-term visits.**

- The communication plan for ongoing services is typically 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**.
- The term **Aid-Essential Communication Situation** shall mean any circumstance in which the importance, length, and complexity of the information being conveyed is such that the exchange of information between parties should be considered as **Aid-Essential**, meaning that the requested auxiliary aid or service is always provided.
- Communication situations will differ from program to program, therefore you will need to identify all situations where you will have contact with a Customer or Companion and develop the plan on how you will communicate with them.

- During follow-up visits or long term care, subsequent requests for the appropriate auxiliary aids and services by the Customer or Companion is not required because this is already captured in their communication plan.
- In each situation requiring an Auxiliary Aid (**whether Aid-Essential or Non-Aid Essential**), you **must** identify in the plan **the name and title of the person responsible for ensuring the auxiliary aid is provided**.
- You must also provide a description of the information being communicated to the customer or companion.

**Example:** Type of Aid: ASL Interpreter Purpose of Aid: GED Class – Instructions on preparation for upcoming test  
 Person responsible for obtaining auxiliary aid: Jane Employee, Case Manager

- In the next table, you will see a list of communication situations that are included in a communication plan. This list is not exhaustive and does not imply there are not other communication situations that may be **Aid-Essential** in a residential setting or during long-term visits.
- Also, the list does not imply that each communication situation listed is **Aid-Essential**. Some communication situations may be of a **Non-Aid Essential Communication Situation**, therefore, the ultimate decision as to what measures to take rests with DCF personnel and DCF Contracted Client Services Providers, provided that they give primary consideration to the request of the Customer or Companion and the method chosen results in effective communication.

#### 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, except during completion of the initial Food Stamp Application

#### □ 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

#### □ Dental:

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

#### □ 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.

#### □ 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

☐ **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

**SECTION 2: AUXILIARY AID/SERVICE REQUESTED AND PROVIDED:**

- Document all auxiliary aids and services requested and provided to the customer
- Indicate the date and time service was provided.
- When an interpreter is a no show, staff will check the box accordingly, and document in section 3 what additional steps were taken to secure an interpreter as required. This may require attaching an additional sheet/s to the form, documenting this process.

**Alternative Auxiliary Aids or Services Provided:**

- Staff may use alternative auxiliary aids or services, in the following situations, which is not an all inclusive list of examples:
  - While waiting for the interpreter to arrive;
  - During non-scheduled appointments or emergency situations;
  - During non-aid essential communication situations;
  - During situations that may constitute a threat to the customer or companions medical condition;
  - When requested by the customer or companion.

**SECTION 3: ADDITIONAL SERVICES REQUIRED:**

- When it is determined that the auxiliary aid and service provided was not effective, staff shall conduct a reassessment of the communication need to determine the appropriate alternative auxiliary aid.
- When staff have determined that the interpreter did not meet their or the customer or companion's expectations, they will document in this section and indicate what additional steps were taken by staff.

**SECTION 4: REFERRAL AGENCY NOTIFICATION:**

- Provide advance notice to referral agencies of the Customer or Companion's requested auxiliary aid or service.
- This section must be documented with a statement indicating that staff notified the referral agency of the Customer or Companion's requested auxiliary aid or service.

**SECTION 5: DENIAL OF AUXILIARY AID/SERVICE:**

- A denial of an auxiliary aid and service should only be done when it is a **non-aid essential** communication
- Staff must still ensure that effective communication is achieved through whatever alternative means are provided.
- DCF Personnel and DCF Contracted Client Services Providers must provide a reason for denial of service.
- Denials can only be made by designated personnel.
- Provide the name and title of person that made the denial determination, along with the time and date.

### **WAIVER FOR FREE INTERPRETER SERVICES**

- If the Customer or Companion declines DCF or DCF Contracted Client Services Provider's offer to provide free auxiliary aids and services, staff shall complete and explain the appropriate form indicating the customer or companion's preferred method of communication.
- DCF Personnel 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 form must be placed in the Customer's medical chart or case file. 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 Request For Free Communication or Waiver of Free Communication Form 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.