

**RCCDC Center Staffing Form**  
Center: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Class #: \_\_\_\_\_ Date: \_\_\_\_\_

Participants: \_\_\_ CM \_\_\_ RA \_\_\_ FA \_\_\_ T \_\_\_ TA \_\_\_ PD \_\_\_ FSM Specialist(s) \_\_\_\_\_

**STRENGTHS/CONCERNS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY SERVICES:**

\_\_\_ Attendance/Tardiness \_\_\_ Custody/Guardianship

DEVELOP IFPA: \_\_\_ FOR: \_\_\_\_\_

ASSIST FAMILY WITH: \_\_\_\_\_

**HEALTH SERVICES:**

RESCREEN: \_\_\_ Hearing PT \_\_\_ Hearing Tymp \_\_\_ Vision \_\_\_ MONITOR: \_\_\_ HT/WT

FOLLOW UP NEEDED FOR: \_\_\_ Hearing \_\_\_ Vision \_\_\_ Dental \_\_\_ Physical \_\_\_ HCT/HGB \_\_\_ Lead

HEALTH CARE PLAN: \_\_\_ In Place \_\_\_ Needed for: \_\_\_\_\_

INITIATE REFERRAL TO: \_\_\_ PCP \_\_\_ ENT OTHER: \_\_\_\_\_

REQUEST RECORDS FOR: \_\_\_\_\_

**DISABILITIES SERVICES:**

IN PLACE: \_\_\_ IEP \_\_\_ IFSP RESCREEN: Fluharty Sections: \_\_\_\_\_ When: \_\_\_\_\_

INITIATE REFERRAL TO: \_\_\_ EarlySteps \_\_\_ LEA Other: \_\_\_\_\_

For Concerns: \_\_\_ Dev \_\_\_ Speech/Language \_\_\_ Motor \_\_\_ Behavior Other: \_\_\_\_\_

DETERMINE/DOCUMENT: \_\_\_ LEA Status \_\_\_ EarlySteps Status

NEED COPIES: \_\_\_ EarlySteps Evaluation \_\_\_ IFSP \_\_\_ LEA Screening Results \_\_\_ LEA Evaluation \_\_\_ IEP

**MENTAL HEALTH SERVICES:**

CONDUCT PARENT CONFERENCE re: \_\_\_ ASQ-SE Other: \_\_\_\_\_

COMPLETE: \_\_\_ MH OBS. \_\_\_ ABC Checklist REQUEST: \_\_\_ MHS Observation \_\_\_ BIP

OBTAIN COPIES of records/reports from: \_\_\_\_\_

**NUTRITION SERVICES:**

REQUEST COPIES OF: Food Allergies/Intolerances

MENU REVISION: \_\_\_ Needed \_\_\_ In Place For: \_\_\_\_\_

INITIATE REFERRAL TO: \_\_\_ WIC \_\_\_ Nutritional Counseling \_\_\_ Workshop Other: \_\_\_\_\_

PROVIDE: \_\_\_ Extra Snack Special Foods: \_\_\_\_\_

**EDUCATION**

COMPLETE: \_\_\_ Home Visit \_\_\_ Parent Conference \_\_\_ Transition Plan

STATUS OF TS GOLD ASSESSMENT: Expectations: \_\_\_ Below \_\_\_ Meeting \_\_\_ Exceeding

**STAFFING ACTION PLAN:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REQUEST SUPPORT FROM: \_\_\_ ED \_\_\_ DIS \_\_\_ H \_\_\_ MH \_\_\_ N \_\_\_ PFCE

REQUEST: \_\_\_\_\_ Specialists' Staffing

**NEXT STEPS:**

TASKS TO COMPLETE	STAFF ASSIGNED	TIMELINE

Center Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_