NIRS Activity Form – FY 2021

***Response Required**

***Program Type:**

☐ UCEDD ☐ LEND ☐ LEAH ☐ PPC ☐ DBP

***Fiscal Year:** **2021**
***Core Function:** **Direct Clinical Services/Model Services**

***Title of Activity:** _____

Brief Activity Description *(This field may be used to provide brief explanatory information (up to 50 words) on the activity being reported in this record)* _____
_____
_____
_____

Staff Involvement _____
(List the first and last name of all staff members who were involved in conducting this activity.)

Name of the clinic _____
Number of unduplicated individuals served _____
(For UCEDDs, this is the Initial Outcome Measure: Number of individuals who receive specialized services from the UCEDD to enhance the well-being and status of the recipient.)

Race of individuals served (Supply number for all that apply)

_____ White
_____ Black or African-American
_____ American Indian and Alaska Native
Tribe:_____
_____ Asian (includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asian)
_____ Native Hawaiian and Other Pacific Islander (includes Native Hawaiian, Guamanian or Chamorro, Samoan, and other Pacific Islander)
_____ More than one race includes individuals who identify with two or more racial designations
_____ Unrecorded is included for individuals who are unable to identify with the categories

Ethnicity of individuals served *(Supply number for all that apply)*

_____ Hispanic _____ Non Hispanic _____ Unrecorded

Ages of individuals served *(Supply number for all that apply)*

_____ Pregnant Women (All Ages)
_____ Infants <1 year
_____ Children 1 to 12 years
_____ Adolescents 12-18 years
_____ Young Adults 18-25 years
_____ CSHCN Infants <1 year
_____ CSHCN Children and Youth 1 to 25 years
_____ Women 25+
_____ Men 25+

***Is this activity addressing the transitional needs to adult health care for youth with special health care needs?**

○ Yes ○ No

***Through what processes are you promoting or facilitating the transition to adult health care for youth with special health care needs?**

○ Technical Assistance
○ Training
○ Product Development
○ Research/Peer-Reviewed publications
○ Outreach/Information Dissemination/Education
○ Tracking/Surveillance
○ Screening/Assessment
○ Referral/Care Coordination
○ Direct Service
○ Quality Improvement Initiatives

***Is this activity promoting and/or facilitating developmental screening and follow-up in your program?**

○ Yes ○ No

***Through what processes are you promoting and/or facilitating screening and follow-up in your program?**

- ○ Technical Assistance
- ○ Training
- ○ Product Development
- ○ Research/Peer-Reviewed publications
- ○ Outreach/Information Dissemination/Education
- ○ Tracking/Surveillance
- ○ Screening/Assessment
- ○ Referral/Care Coordination
- ○ Direct Service
- ○ Quality Improvement Initiatives

***Area of Emphasis** *(Check one)*

Areas listed in the DD Act:

- ○ Quality Assurance Activities
- ○ Child Care-Related Activities
- ○ Employment-Related Activities
- ○ Transportation-Related Activities
- ○ Education & Early Intervention
- ○ Health-Related Activities
- ○ Housing-Related Activities
- ○ Recreation-Related Activities

Areas not listed in the DD Act:

- ○ Quality of Life Activities
- ○ Other-Cultural Diversity
- ○ Other, Please Specify:

  _____
- ○ Other-Assistive Technology
- ○ Other-Leadership

Customer Satisfaction

***Was the Center the lead on this activity?**

- ○ Yes *(If Yes, please enter the survey results below.)*
- ○ No

Total number surveyed _____ Supply total number responding:

Strongly Agree _____ Disagree _____

Agree _____ Strongly Disagree _____

***Primary Agency Collaborating on the Work of the Activity** *(Select one)*

- ☐ Not Applicable/No Collaborating Agency

- ○ State Title V Agency
- ○ Other MCHB Funded or Related Program
- ○ State Health Dept.
- ○ Clinical Programs/Hospitals
- ○ State Adolescent Health
- ○ Other Health-Related Program
- ○ Health Insurance/Managed Care Organization
- ○ Medicaid
- ○ Development Disabilities Council
- ○ Protection & Advocacy Agency (P&A)
- ○ Another UCEDD
- ○ Childcare/Early Childhood/Part C Infants and Toddlers
- ○ Head Start/Early Head Start
- ○ State/Local Special Education (3-21)
- ○ State/Local General Education
- ○ Post Secondary Education (Community College-University)
- ○ Employment/Voc Rehab
- ○ State/Local DD Agency or Provider
- ○ State/Local Social Services
- ○ Aging Organization
- ○ Health Agency - Public/Private
- ○ Mental Health/Substance Abuse Agency
- ○ Housing Agency/Provider
- ○ Recreation Agency
- ○ Transportation Agency
- ○ Provider Organization
- ○ Consumer/Advocacy Organization
- ○ State/Local Coalition
- ○ Legislative Body
- ○ Justice/Legal Organization
- ○ Community or Faith-Based Organization
- ○ National Association
- ○ Independent research or policy organization
- ○ Foundation
- ○ Other

***All Agencies Collaborating on the Work of the Activity** (Must check all that apply)

(Name of agency/ies may be supplied in space provided)

- ☐ State Title V Agency _____
- ☐ Other MCHB Funded or Related Program _____
- ☐ State Health Dept. _____
- ☐ Clinical Programs/Hospitals _____

- ☐ State Adolescent Health _____
- ☐ Other Health-Related Program _____
- ☐ Health Insurance/Managed Care Organization _____
- ☐ Medicaid _____
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- ☐ Housing Agency/Provider _____
- ☐ Recreation Agency _____
- ☐ Transportation Agency _____
- ☐ Provider Organization _____
- ☐ Consumer/Advocacy Organization _____
- ☐ State/Local Coalition _____
- ☐ Legislative Body _____
- ☐ Justice/Legal Organization _____
- ☐ Community or Faith-Based Organization _____
- ☐ National Association _____
- ☐ Independent research or policy organization _____
- ☐ Foundation _____
- ☐ Other _____

***Project Affiliation**

- ☐ Not Applicable/No Affiliated Project
  Primary Affiliated Project – List Title: _____
  Secondary Affiliated Project– List Title: _____

***Duration** (Report to the nearest full hour): _____

- ☐ Not Applicable

  Date of Activity _____
  (mm/dd/yyyy)

- ☐ Recurring activity?
  (For on-going activities, you may just enter the date the activity began)