

NIRS Activity Form – FY 2021

***Response Required**

***Program Type:**

- UCEDD
 LEND
 LEAH
 PPC
 DBP

***Fiscal Year:** 2021

***Core Function:** Interdisciplinary Preservice Preparation (Training Trainees)

***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.)

***Type of Activity (Select one)**

- Advocacy
 Capacity Building
 Systemic Change

***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?**

- | | |
|--|---|
| <input type="radio"/> Technical Assistance | <input type="radio"/> Tracking/ Surveillance |
| <input type="radio"/> Training | <input type="radio"/> Screening/ Assessment |
| <input type="radio"/> Product Development | <input type="radio"/> Referral/ Care Coordination |
| <input type="radio"/> Research/ Peer-reviewed publications | <input type="radio"/> Direct Service |
| <input type="radio"/> Outreach/ Information Dissemination/ Education | <input type="radio"/> 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 developmental screening and follow-up in your program?**

- | | |
|--|---|
| <input type="radio"/> Technical Assistance | <input type="radio"/> Tracking/ Surveillance |
| <input type="radio"/> Training | <input type="radio"/> Screening/ Assessment |
| <input type="radio"/> Product Development | <input type="radio"/> Referral/ Care Coordination |
| <input type="radio"/> Research/ Peer- Reviewed Publications | <input type="radio"/> Direct Service |
| <input type="radio"/> Outreach/ Information Dissemination/ Education | <input type="radio"/> Quality Improvement Initiatives |

***Was the training conducted outside the UCEDD?**

- Yes
 No

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

<input type="radio"/> Technical Assistance	<input type="radio"/> Tracking/ Surveillance
<input type="radio"/> Training	<input type="radio"/> Screening/ Assessment
<input type="radio"/> Product Publication	<input type="radio"/> Referral/ Care Coordination
<input type="radio"/> Research/ Peer-reviewed publications	<input type="radio"/> Direct Service
<input type="radio"/> Outreach/ Information Dissemination/ Education	<input type="radio"/> 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

***Types and Numbers of Participants (Supply number for all that apply)**

<input type="checkbox"/>	Audiology	<input type="checkbox"/>	Medicine-Adolescent Medicine
<input type="checkbox"/>	Biological Sciences	<input type="checkbox"/>	Medicine: General
<input type="checkbox"/>	Dentistry- Other	<input type="checkbox"/>	Medicine: Pediatric
<input type="checkbox"/>	Dentistry- Pediatric	<input type="checkbox"/>	Mental and Behavioral Health
<input type="checkbox"/>	Disability Studies	<input type="checkbox"/>	Nursing- Midwife
<input type="checkbox"/>	Education: Administration	<input type="checkbox"/>	Nursing-Family/Pediatric Nurse Practitioner
<input type="checkbox"/>	Education: Early Intervention/Early Childhood	<input type="checkbox"/>	Nursing
<input type="checkbox"/>	Education: General Education	<input type="checkbox"/>	Nursing-Other
<input type="checkbox"/>	Epidemiology	<input type="checkbox"/>	Nutrition
<input type="checkbox"/>	Family Studies	<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Education/Special Education	<input type="checkbox"/>	Pastoral
<input type="checkbox"/>	Gerontology	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Family/Parent/Youth Advocacy	<input type="checkbox"/>	Pharmacy
<input type="checkbox"/>	Genetics/Genetics Counseling	<input type="checkbox"/>	Psychiatry
<input type="checkbox"/>	Health Administration	<input type="checkbox"/>	Psychology
<input type="checkbox"/>	Human Development/Child Development	<input type="checkbox"/>	Public Administration
<input type="checkbox"/>	Interdisciplinary	<input type="checkbox"/>	Public Health
<input type="checkbox"/>	Law	<input type="checkbox"/>	Rehabilitation
<input type="checkbox"/>	Liberal Arts & Sciences, Humanities, & General Studies	<input type="checkbox"/>	Respiratory Therapy
<input type="checkbox"/>	Medicine-Pediatric Pulmonology	<input type="checkbox"/>	Social Work
<input type="checkbox"/>	Medicine-Neurodevelopmental Disabilities	<input type="checkbox"/>	Speech-Language Pathology
<input type="checkbox"/>	Medicine-Developmental-Behavioral Pediatrics	<input type="checkbox"/>	
<input type="checkbox"/>	Other - Please specify discipline:	<input type="checkbox"/>	

Trainees Total (sum of numbers above) _____
 Other Classroom Students _____
 Professionals & Para-Professionals _____
 Family Members/Caregivers _____

Adults with Disabilities _____
 Children/Adolescents with Disabilities/SHCN _____
 Legislators/Polymakers _____
 General Public/Community Members _____

***Discipline of Course Or Class**

- Audiology
- Biological Sciences
- Dentistry- Other
- Dentistry- Pediatric
- Disability Studies
- Education/Special Education
- Education: Administration
- Education: Early Intervention/Early Childhood
- Education: General Education
- Epidemiology
- Family Studies
- Family/Parent/Youth Advocacy
- Genetics/Genetics Counseling
- Gerontology
- Health Administration
- Human Development/Child Development
- Interdisciplinary
- Law
- Liberal Arts & Sciences, Humanities, & General Studies
- Medicine-Adolescent Medicine
- Medicine-Developmental-Behavioral Pediatrics
- Medicine-Neurodevelopmental Disabilities
- Medicine-Pediatric Pulmonology
- Medicine: General
- Medicine: Pediatric

- Mental and Behavioral Health
- Nursing
- Nursing-Family/Pediatric Nurse Practitioner
- Nursing-Midwife
- Nursing-Other
- Nutrition
- Occupational Therapy
- Other
- Pastoral
- Pharmacy
- Physical Therapy

- Psychiatry
- Psychology
- Public Administration
- Public Health
- Rehabilitation
- Respiratory Therapy
- Social Work
- Speech-Language Pathology
- If Other is selected, please specify Discipline:

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 _____

***Initial Outcome Measure**

UCEDD long term trainees reporting an increase in knowledge or skills and/or change in attitude

Total number surveyed _____
 Supply total number responding: _____
 Strongly Agree _____ Disagree _____
 Agree _____ Strongly Disagree _____
 Not Applicable

***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 _____
- 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 _____
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- 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)