RE® PerformCARE[®] Child/Adolescent Services Feedback Form

Please forward this form to the agency or provider that requested your feedback.

Agency/Provider Name Requesting Feedback:	Fax number:
Today's Date:	
Child's Name:	MAID #, if known
D.O.B	
🗌 Cumberland 🔲 Dauphin 🔲 Franklin 🗌 Fulton 🗌 Lancaster 🗌 Lebanon 🗌 Perry	
Name of Person Providing Feedback:	
Organization/Relationship to the Child:	Phone #:
In which settings have you observed the child? Home Community School Other	
Section #1-School	
School Name:	Grade:
	ments, describe the amount of time spent in each setting.
🗌 Day Care 🔲 Head Start 🔲 Preschool 🗌 IU Preschool 🗌 Charter School 🗌 Private School 🗌 Home Schooling	
🗌 Regular Ed 🔲 Autistic Support 🗌 Emotional Support 📄 Learning Support 📄 Life Skills 📄 Alternative Education	
🗌 504 Plan 🔄 Home Bound 🔄 RTF School 🔄 Other:	
Comments	
Does the child have an IEP? Yes No N/A	
Is there a Behavior Support Plan within the IEP?	
Are there other aids in the classroom? \Box Yes \Box No \Box N/A	
What is the student to teacher ratio in the classroom/s?	
Indicate if the child receives any additional services in the school setting, if applicable.	
Speech Therapy Occupational Therapy	Physical Therapy 🗌 Other:
Please comment on the child's behavior in the schools	s listed below. Please be as specific as possible about how often behaviors
occur.	
Classroom behavior	

Capital Members: 1-888-722-8646 Franklin/Fulton Members: 1-866-773-7917 Providers: 1-888-700-7370 Fax: 1-855-707-5823 Mailing Address: 8040 Carlson Road Harrisburg, PA 17112



Peer relationships

Less structured school settings (cafeteria, home room, recess, etc.)

Section #2-Home/Community/Other

Behavior Observed in Home/Community/Other setting:

Section #3-Additional comments

Please comment on any concerns or ongoing issues that you feel need to be addressed in the treatment of the child or family.

Are you in support of the child receiving Behavioral Health Services? Yes No Please indicate type of service and explain why:

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