FSCD Parent Preparation Workbook

Complete This Before Your First Caseworker Meeting

A step-by-step workbook for families of children with disabilities in Alberta | Parent Partnership Project | April 2026

Complete this workbook BEFORE your first meeting with your FSCD caseworker.
The more prepared you are, the faster your family can access the supports you need.

Child's Name:	
Date of Birth:	
Parent / Guardian Name:	
Date Completed:	

How to Use This Workbook

Read this page before you begin

Due to high demand and caseworker waitlists, the Parent Partnership Project has created this workbook so that families can prepare as much as possible before meeting with an FSCD caseworker. The more complete your answers, the faster your agreement can be built and activated.

> **Important Note:** *The resources and forms in this workbook are designed to prepare you for FSCD. Completing this workbook* **does NOT** *start your FSCD agreement — it prepares you so your first caseworker meeting can move as quickly and efficiently as possible.*

What You Will Do in This Workbook

- Step 1 — Gather basic information about your child (feeds into FCAON Part 1)
- Step 2 — Document your family situation (feeds into FCAON Part 2)
- Step 3 — Work through each FCAON assessment domain so you are ready to discuss your child's needs
- Step 4 — Draft your family's vision and goals for the Individualized Family Support Plan (IFSP)
- Step 5 — Review The Menu so you know what services exist
- Step 6 — Learn about Specialized Services (if relevant to your child)
- Step 7 — Understand your rights and the appeal process
- Step 8 — Use the Forms Checklist to confirm everything is ready

What to Bring to Your First Meeting

- This completed workbook
- Medical documentation confirming your child's diagnosis
- Names and contact details for all health professionals involved in your child's care
- A list of current medications and their purposes
- Any recent assessments (psychological, speech-language, OT, PT, etc.)
- Your child's school or program information
- Information about any government benefits your family currently receives
- Your most recent tax return (line 23600) — needed if requesting health benefits

> *You cannot access any FSCD services or receive any reimbursement until your agreement has been approved by a Supervisor or Manager, signed by you, and activated in the FSCD system. Services cannot start before a signed agreement —* **no exceptions.**

1 About Your Child

This information feeds directly into FCAON Part 1 — Assessment Information

Assessment Type

Please indicate which of the following applies to your child:

☐ **Initial Assessment** *(First time applying to FSCD)*	☐ **Reopen** *(Returning after file was closed)*	☐ **Reassessment** *(Renewing an existing agreement)*

Child Information

Child's Full Name

Date of Birth (yyyy-mm-dd)	
FSCD File #	

Diagnostic Information

List all diagnoses your child has received. Bring written documentation to your meeting.

Diagnosis	Date of Diagnosis	Health Professional	Docs Provided?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Health Care Professionals Involved in Your Child's Care

Name	Discipline / Role	Phone Number	Frequency

Current Medications

List medications prescribed by a physician related to your child's disability.

Medication Name	Purpose	Past 12 Months?	Impact on Child
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Education and Programs

School / Program Name	Grade / Level / Type	Days/Week	Hrs/Day

Does your child have an Individualized Program Plan (IPP)? ☐ Yes ☐ No

If yes, describe the goal areas being worked on:

Extraordinary supports your child receives at school (e.g. aide, FM system, specialized equipment):

2 Your Family Situation

This prepares you for FCAON Part 2 — Child and Family Support & Service Planning

Family Composition

Who lives in your home? List all household members — names, relationships, ages.

Are there family members or others outside the home who help support your child? (e.g. grandparents, aunts/uncles, friends, neighbours)

Daily Routines

Your caseworker needs to understand how your family's day-to-day life is affected by your child's disability. Think about mornings, mealtimes, school drop-off, evenings and weekends. Use the blank monthly calendar at the back of this workbook to map out two school month weeks, one short vacation week (ie Christmas or spring break), and one long vacation week (ie summer holidays), and bring it to your meeting.

Describe your family's typical daily routine. What is working well? What is difficult or exhausting?

Does your child have a predictable schedule? Describe any routines that are particularly important or challenging.

Community and Recreational Activities

What activities does your family participate in together? (e.g. sports, community events, church, disability support groups)

Are there activities your family would like to participate in but cannot because of your child's disability? Describe the challenges.

Dealing with Your Child's Disability

Do all caregivers in your home understand your child's disability and care needs? Are there any concerns about how the disability affects your family emotionally or practically?

Are there values or beliefs that influence the type of support you are comfortable with? (e.g. having caregivers in the home, particular therapies)

Siblings

Are there other children in the home? How does your child's disability affect them — responsibilities, peer relationships, family dynamics?

Emotional and Physical Wellbeing of Caregivers

Do you or other caregivers have health issues that affect your ability to provide care? Are there others outside the home who depend on you (e.g. elderly parents)?

Government Programs Currently Accessed

Check all that apply and note the current status.

Program	Accessing?	Notes / Details
Child Disability Benefit	☐ Yes ☐ No ☐ Applied	
Child Care Subsidy	☐ Yes ☐ No ☐ Applied	
Inclusive Child Care	☐ Yes ☐ No ☐ Applied	
Child Intervention Services	☐ Yes ☐ No ☐ Applied	
Family Enhancement Services	☐ Yes ☐ No ☐ Applied	
Supports for Permanency (SFP)	☐ Yes ☐ No ☐ Applied	
Homecare	☐ Yes ☐ No ☐ Applied	
Aids to Daily Living (AADL)	☐ Yes ☐ No ☐ Applied	
Income Support	☐ Yes ☐ No ☐ Applied	
Persons with Developmental Disabilities (PDD)	☐ Yes ☐ No ☐ Applied	
Assured Income for the Severely Handicapped (AISH)	☐ Yes ☐ No ☐ Applied	
Alberta Child Health Benefit	☐ Yes ☐ No ☐ Applied	
Disability Tax Credit	☐ Yes ☐ No ☐ Applied	
Funding for First Nations (Non-Insured Health Benefits)	☐ Yes ☐ No ☐ Applied	

3 The FCAON — Child's Care Needs Assessment

Your caseworker will complete this form with you — thinking through it now makes your meeting far more productive

About the Caregiver Assistance Scale (0–5)
For each activity, rate how much physical help your child needs from you:
5 = Independent — no assistance or supervision needed
4 = Supervision/Setup — you must be present or set things up, but no physical help
3 = Minimal Assistance — very little help (e.g. close guarding, occasional steadying)
2 = Moderate Assistance — you do less than half of the activity
1 = Maximal Assistance — you do more than half
0 = Total Assistance — you do almost everything; child provides no meaningful participation

Domain 1: Mobility

Does your child require assistance due to limited mobility? ☐ Yes ☐ No

Chair / Toilet Transfers	**How well does your child transfer to/from a wheelchair, adult-sized chair, or adult toilet?** *Think about getting up from the couch, using a public washroom, sitting in a classroom chair.* Score (0–5): ____
Car Transfers	**How independently does your child get in/out of the car, manage seat belts, and open/close doors?** *Consider whether they need a special seat, harness, or adult assistance.* Score (0–5): ____
Bed Mobility	**How well does your child get in and out of bed and change positions in their own bed?** Score (0–5): ____
Tub Transfers	**How independently does your child get in and out of an adult-sized tub?** Score (0–5): ____
Indoor Locomotion	**How independently does your child move through 3–4 rooms (about 50 feet) indoors?** *Do not include opening doors or carrying objects.* Score (0–5): ____
Outdoor Locomotion	**How independently does your child move outdoors on level surfaces (about 15 car lengths)?** *Focus on physical ability only — do not factor in compliance with safety rules.* Score (0–5): ____
Stairs	**How independently does your child climb and descend a full flight of stairs (12–15 steps)?** Score (0–5): ____

Comments on mobility. List any equipment or modifications used (e.g. wheelchair, walker, grab bars, lift device):

Domain 2: Self-Care

Does your child need assistance with self-care? ☐ Yes ☐ No

Caregiver Scale (0–5)	Toileting Scale (0–5)
5 = Independent — Caregiver provides no physical assistance or supervision. 4 = Supervision/Setup — Caregiver provides no physical help during the activity, but it is needed to monitor, provide verbal directions, or set up self-care equipment or materials. 3 = Minimal Assistance — Caregiver provides very little assistance, such as occasional stabilization or assistance with the completion of an activity. 2 = Moderate Assistance — Caregiver does less than half of the activity. 1 = Maximal Assistance — Caregiver does more than half of the activity; child provides meaningful assistance. 0 = Total Assistance — Caregiver does almost all of the activity; child provides no meaningful assistance.	5 = Independent — Caregiver provides no physical assistance or supervision. 4 = Supervision/Setup — Caregiver provides no physical help during activity or accident clean-ups, but it is needed to monitor continence, to remind child of need for bathroom use, provide verbal directions, or to set up toileting equipment or materials. 3 = Minimal Assistance — Caregiver provides very little assistance, such as occasional assistance in completing toileting tasks; only occasional accident cleanup is necessary (not to exceed 1–2 events per week). 2 = Moderate Assistance — Caregiver does less than half of the toileting tasks; child more than half of the time successfully uses toilet, potty or external device (not diapers). 1 = Maximal Assistance — Caregiver does more than half of the toileting tasks; child provides meaningful assistance (such as using potty), but child more than half the time has accidents or uses diapers. 0 = Total Assistance — Caregiver does almost all of the toileting tasks and cleanup of accidents; child provides no meaningful assistance.

Activity	Question
Eating	**How independently does your child eat and drink a regular meal?** *Do not include cutting steak, opening containers, or serving from dishes.* Score (0–5): ____
Grooming	**How independently does your child brush teeth, brush/comb hair, and care for their nose?** Score (0–5): ____
Bathing	**How independently does your child wash/dry face and hands, take a bath or shower?** *Do not include getting in/out of tub or washing back/hair.* Score (0–5): ____
Dressing — Upper Body	**How independently does your child put on/take off indoor clothes on the upper body?** *Include splints or artificial limbs. Do not include back fasteners or getting clothes from drawers.* Score (0–5): ____
Dressing — Lower Body	**How independently does your child put on/take off indoor clothes on the lower body?** *Include braces or artificial limbs. Do not include getting clothes from drawers.* Score (0–5): ____
Toileting	**How independently does your child manage toilet use, clothing, and hygiene during toileting?** *Do not include transfers or monitoring a schedule. Use Toileting Scale above.* Score (0–5): ____
Bladder Management	**How independently does your child manage bladder control day and night?** *Include clean-up after accidents and monitoring schedule. Use Toileting Scale above.* Score (0–5): ____
Bowel Management	**How independently does your child manage bowel control day and night?** *Include clean-up after accidents and monitoring schedule. Use Toileting Scale above.* Score (0–5): ____

Comments on self-care. List any equipment or modifications used:

Domain 3: Social Functioning

Caregiver Scale — Functional Comprehension & Expression (0–5)	Caregiver Scale — Joint Problem Solving, Peer Play & Safety (0–5)
5 = Independent — Caregiver rarely needs to make adjustments or prompt; child can understand and/or be readily understood by others. 4 = Prompting/Setup — Caregiver or other adult may need to give some prompting or cueing when child is communicating with less familiar people, or caregiver may need to set up equipment or modifications for communication. 3 = Minimal Assistance — Caregiver makes occasional adjustments (requests more information about less familiar topics or provides additional explanations); child understands almost all requests and/or expresses him/herself clearly almost all of the time; child may initiate clarification. 2 = Moderate Assistance — Caregiver makes frequent adjustments (pauses, repetitions, clarifications); child generally can understand one or two step requests and/or uses simple language. 1 = Maximal Assistance — Caregiver makes very frequent adjustments to make communication possible (simplification of requests, repetitions, interpretations of child's communications). 0 = Total Assistance — Caregiver makes almost constant adjustments (language simplifications, gestures, interpretation of child's communication) to make communication possible; child has extremely limited communication skills.	**Joint Problem Solving:** 5 = Independent — Caregiver and child can work cooperatively to solve difficult problems: child effectively initiates and participates in problem solving. 4 = Prompting/Setup — Caregiver or other adult may need to give some prompting or cueing when child is problem solving with people other than caregiver. 3 = Minimal Assistance — Caregiver occasionally needs to provide direction to solve difficult problems; child can communicate about simple problems and generate solutions almost all of the time. 2 = Moderate Assistance — Caregiver must frequently direct problem-solving effort; child can communicate effectively about most simple problems but needs help identifying solutions. 1 = Maximal Assistance — Caregiver must very frequently direct child to help identifying problem; child can provide information about problem in response to caregiver prompts. 0 = Total Assistance — Caregiver must identify and find solutions for almost all problems; child does not effectively communicate problems or participate in solutions. **Safety:** 5 = Independent — Child can routinely initiate and complete activity. 4 = Supervision/Setup — Caregiver monitors child's activity to ensure safety/appropriate peer activity and to help deal with unusual circumstances. 3 = Minimal Assistance — Caregiver provides very little direction of activity, but may need to occasionally intervene. 2 = Moderate Assistance — Caregiver must frequently direct child's participation; child often initiates appropriate activity. 1 = Maximal Assistance — Caregiver very frequently must direct child's participation; child can follow adult cues. 0 = Total Assistance — Caregiver does almost all of the activity; child rarely participates.

Functional Comprehension	**How well does your child understand requests and instructions from others?** *Consider how they respond with familiar people vs. strangers. Use Comprehension/Expression scale.* Score (0–5): ____
Functional Expression	**How well does your child communicate their own needs and activities to others?** *Consider clarity of speech and how well strangers understand them. Use Comprehension/Expression scale.* Score (0–5): ____
Joint Problem Solving	**How well does your child communicate about problems and work with you to find solutions?** *Think about everyday conflicts — a lost toy, disagreement over clothing choices, etc.* Score (0–5): ____

Peer Play	**How well does your child plan and carry out activities with a familiar peer?** Score (0–5): ____
Safety	**How independently does your child stay safe in routine daily situations?** *Consider stairs, sharp/hot objects, and traffic.* Score (0–5): ____

Comments on communication and social skills. List any modifications used (e.g. hearing aid, AAC device, sign language, communication board):

Domain 4: Behaviour

Does your child require assistance with behaviour? ☐ Yes ☐ No

Rate the Impact (1–5) and Frequency (1–5) for behaviours in the past 6 months. Note a behaviour if it is atypical for their age AND impacts safety or daily life participation.

IMPACT Scale (1–5)	**FREQUENCY Scale (1–5)**
5 = No direction needed 4 = More monitoring than typical 3 = Ongoing support / pre-planning needed 2 = Often removed from activities 1 = Cannot participate in many daily activities	5 = Never 4 = Occasionally (monthly) 3 = Often (several times/week) 2 = Regularly (several times daily) 1 = Constant

Behaviours Impacting Participation and Caregiver Demands

Behaviour	Impact (1–5)	Frequency (1–5)	Applies?
Temper tantrums			☐ Yes ☐ No
Behaves inappropriately in public (embarrassing comments, eating others' food, clinging to strangers)			☐ Yes ☐ No
Impulsive / does not think before acting			☐ Yes ☐ No
Fidgets / difficulty attending to tasks			☐ Yes ☐ No
Obsesses / perseverates			☐ Yes ☐ No
Smears			☐ Yes ☐ No
Eating/food issues (refuses to eat, binge eating)			☐ Yes ☐ No
Disruptive noises (attention-seeking, yelling)			☐ Yes ☐ No
Difficulty getting to sleep			☐ Yes ☐ No
Frequent night-time waking			☐ Yes ☐ No
Other (describe in comments below)			☐ Yes ☐ No

Behaviours Impacting Safety of Self or Others

Behaviour	Impact (1–5)	Frequency (1–5)	Applies?
Aggressive to others physically (hitting, spitting)			☐ Yes ☐ No
Destructive to property			☐ Yes ☐ No
Abusive to animals			☐ Yes ☐ No
Self-abusive			☐ Yes ☐ No
Engages in inappropriate sexual activity			☐ Yes ☐ No
Runs away / whereabouts not known to guardian			☐ Yes ☐ No
Illegal activities (theft, vandalism, substance abuse)			☐ Yes ☐ No

4 Your Vision and Goals — Preparing for the IFSP

The Individualized Family Support Plan documents your vision, goals, and strategies to achieve them

Your caseworker will complete the IFSP with you. Thinking through your vision and goals beforehand means your meeting will be spent confirming and refining — not starting from scratch.

What makes a good goal? (SMART Goals)
Goals should be: Specific, Measurable, Attainable, Realistic, and Timely.
A good goal describes a future state — not just a service. Example:
✔️ *"By June, [child's name] will attend a community soccer program with peer support one day per week."*
✘ *"We want respite care." (This is a service, not a goal.)*
Focus on the top 2–3 goals that would make the biggest positive difference for your family in the next year.

Your Family's Vision In your own words, what is your vision for your child and family? What do you hope life looks like for your child — this year, in 5 years, as an adult?

Goal 1 — Top Priority What is the most important change you want to see for your child or family in the next year?

What strategies or supports would help achieve this goal? Who would be involved?

Goal 2 — Second Priority Describe your second priority goal.

What strategies or supports would help achieve this goal? Who would be involved?

Goal 3 — Third Priority (if applicable) Describe your third goal if you have one.

What strategies or supports would help achieve this goal? Who would be involved?

Other Concerns or Priorities Is there anything else your caseworker should know about your child's needs or your family's situation that does not fit into the sections above?

5 The FSCD Services Menu

Review the full list of available supports so you can discuss what may apply to your family

The Menu below shows every service available through FSCD. Family Support Services (left) are available to all eligible families. Child Focused Services (right) require an individual needs assessment.

Read through The Menu, then use the checklist below to flag which services you think may apply to your child and family. Your caseworker will confirm eligibility based on your assessment.

Family support services (FSS) – FSS are available to all children/families who are eligible for the FSCD program

Information, referral and advocacy

- Information for parents concerning the child's disability and available services and resources
- Advocacy as well as referral to advocacy supports
- Assistance with obtaining and coordinating supports and services
- Transitional planning

Related support

- Disability related clothing and footwear up to $400 annually
- Family and individual counselling up to 20 hrs annually

Medical appointments/ hospitalizations

- Mileage @ 12¢/km for medical appointment/ rehabilitation or the most economical and appropriate alternative when the guardian does not have access to a vehicle
- Parking to a maximum of $10/day
- Sibling care when required in order for an adult to accompany child to medical appointment/rehabilitation
- Meals & Accommodations:
  For day trips over 8 hrs for medical appointment/ rehabilitation:
  - meals for adult up to $8/day
  - meals for child up to $5/day

  OR If overnight accommodation is required:
  - up to $85/night for accommodations
  - costs for meals/day: $15 for 1 adult and $10 for the child (if the child is not in hospital or other medical accommodations)

  OR
  - up to $100/wk for groceries for 1 adult and the child
  - additional meals @ $15/day or grocery costs @ $50/wk for a second adult as well as transportation costs if required
- Costs for mileage, parking, sibling care and meals for out of province medical care as approved by Health

Family support respite support

- In or out of home respite up to 240 hrs annually (based on 20 hrs/mth)

Legend

- (Blue) No assessment required.
- (Green) Additional information from the parent, a professional or a service provider knowledgeable about the child, may be required to help determine need and level of service
- (Pink) Multidisciplinary assessment information (including only those disciplines and information, which are relevant to the child and their needs) is required to determine the nature and level of needs, appropriate supports and to develop a service plan

"Service provider" refers to any agency or private individual who provides a service.

Child focused services – available in addition to family support services based on individually assessed needs for children whose disability results in significant limitations in their ability function in activities of normal daily living (e.g. communicating, feeding, dressing, toileting, decision-making)

Child focused respite services

- In or out of home short-term hourly respite based on the needs of the child and family
- 24-hour (in or out of home) respite to a maximum of 30 days/year based on needs of child and family
- Additional 24-hour (out of home) respite where required to maintain the child in guardian's residence
- Costs for public transportation when the guardian does not have access to a vehicle for transportation to/from 24-hour out of home respite care
- Homemaking services for routine housekeeping and laundry services up to 12 hrs/mth
- Coordinated in home support up to 50 hrs/wk (nanny/domestic)

Child care supports

- Extraordinary portion of work related child care costs for children up to age 13
- Work related child care costs for children age 13 and older
- Aide in day care for work related child care
- Costs of additional space in a family day home for work related child care
- Aide in day care and/or daycare costs for up to a max of 4 hrs/ weekday to a maximum of 20 hrs/wk for children who require day care for developmental purposes awaiting commencement of preschool programming

Aide supports

- Personal care and hygiene supports for up to 4 hrs/day
- Community support for a maximum 144 hrs annually
- Behavioural and/or Developmental Supports to address an identified need for aide supports for up to 10 hrs/wk for 6 mths at which time the service will be reviewed

  Requires a plan with goal focused strategies that are based on established/evidence based practices

Health related supports

- Portion of disability related dental/ orthodontic treatment not covered by guardian's insurance as approved by the Dental Review Committee
  - guardians are responsible for the first $250/yr in lieu of having a dental insurance plan
- Funding for prescription drugs
  1) up to 30% of drug costs, or
  2) a second insurance plan if the cost of drugs in 1) exceeds the cost of second plan
  3) interim prescription drugs pending application for insurance coverage for up to 4 mths
  4) the full costs of the prescription drugs if less than the cost of the guardian's insurance plan
- Ambulance costs while awaiting application for insurance coverage (up to 4 mths)
- Prescription formula costs
- Medically prescribed specialized diet costs
- Medical benefits required to sustain life or when it would be debilitating if the benefit was not received and the benefit:
  - is available in Alberta;
  - is based on established rehabilitation practices, strategies and approaches;
  - would result in significant financial hardship; and
  - is not provided in whole or in part by another program

Specialized services For children with severe disabilities

Direct support for children and support to the family to address critical areas of need in 2 or more areas, including:

- behavior
- communication and socialization skills
- cognitive abilities
- physical and motor development
- self-help and adaptive functioning

Coordinated and delivered through a specialized services team involving health professionals relevant to the child's areas of need (e.g. Speech- Language Pathologists, Occupational and Physical Therapists and Psychologists; as well as behavioural specialists and aides

Requires an Individualized Service Plan, identifying individualized strategies that are goal focused and faced on established / evidence based practices

"*Severe disability*" means a condition or impairment that

- results in a major loss of the child's functional ability or capacity to engage in the activities of normal daily living, and
- requires the guardian and other caregivers to provide continual and ongoing supervision, assistance and support in the activities of normal daily living to ensure the child's safety or to facilitate the child's participation at home and in the community

Out of home living arrangement

- To support a child to live in a setting outside of the family home
- Transportation to and from home living arrangement @ 12¢/km or the most economical alternative when the guardian does not have access to a vehicle

Notes:

Services I Think May Apply to My Family

Check the services below that you would like to discuss with your caseworker.

Family Support Services (FSS)	Child Focused Services (CFS)
☐ Information, referral and advocacy	☐ Child focused respite (short-term / hourly)
☐ Disability-related clothing and footwear	☐ 24-hour in or out of home respite
☐ Medical appointment mileage (up to $0.12/km)	☐ Extended respite (host/foster/group/residential)
☐ Parking for medical appointments	☐ Homemaking services
☐ Sibling care during medical appointments	☐ Domestic child care
☐ Meals and accommodation for medical appointments	☐ Work-related child care (under 13)
☐ Out-of-province medical care supports	☐ Work-related child care (13 and older)
☐ Family or individual counselling (up to 20 hrs/year)	☐ Aide in day care / child care facility
☐ Family respite — up to 240 hrs/year	☐ Personal care and hygiene supports (aide)
☐ Triple P (Positive Parenting Program)	☐ Community support (aide)
☐ Transitional planning	☐ Behavioural support
	☐ Developmental support
	☐ Dental and orthodontic treatment
	☐ Prescription drugs
	☐ Prescribed formula / special diet
	☐ Medical benefits (financial hardship)
	☐ Ambulance services
	☐ Specialized Services
	☐ Out of home living arrangement

Notes:

6 Specialized Services

Complete this section only if your child may need intensive, coordinated support

Specialized Services are an intensive level of support for children whose disability results in significant limitations in 2 or more areas: behaviour, cognitive ability, physical and motor development, and/or self-help and adaptive functioning.

What Specialized Services include:

• A coordinated team of health professionals (e.g. Speech-Language Pathologist, Occupational Therapist, Physical Therapist, Psychologist, Behavioural Specialist)

• An Individualized Support Plan (ISP) with goal-focused, evidence-based strategies — reviewed at least 4 times per year

• Decisions made within 15 working days (unless a Multi-Disciplinary Team review is required)

Note: *Participation in Triple P is NOT required before receiving Specialized Services*

Do you believe your child may need Specialized Services? ☐ Yes ☐ Not sure ☐ No

Describe the areas where your child has the most significant limitations and how these affect daily functioning at home and in the community:

List any assessments completed by professionals (OT, SLP, PT, Psychologist) — include the professional's name, date, and where you can get a copy:

See Specialized Services Workbook for more details.

7 Your Rights and Options

Know your options before your first meeting

If You Disagree with an FSCD Decision

Your caseworker is required to explain these options to you. You always have the right to:

Option	What It Means
Talk to Your Caseworker	Always the first step. Ask for clarification, provide additional information, or discuss alternatives.
Request a Review	A formal review of the FSCD program decision.
Mediation	A neutral third party helps you and FSCD reach a resolution. You must request this within the timeline on your written decision letter.
Formal Appeal	File a formal appeal. The date on the written decision letter starts your timeline. A Notice of Appeal form is included in this package.

Your Privacy

FSCD is committed to protecting your personal information. Before collecting any information, your caseworker will explain why it is being collected, how it will be used, and who it may be shared with. Your information is used only to determine eligibility and plan appropriate supports.

When FSCD Services End

- FSCD services end the day before your child's 18th birthday.
- Contract transition begins 3 - 6 months before this date.
- If your child is 16 or older, a Transition to Adulthood Plan (TAP) replaces the IFSP.
- You can always reapply to FSCD if your family's circumstances change in the future.

Notes:

8 Forms Checklist

Use this checklist to confirm everything is in order before your first meeting

Form / Document	When	Status
This workbook (completed)	*Bring to first meeting — completed by you*	☐ Done / In progress
Proof of diagnosis / medical documentation	*Bring to first meeting*	☐ Have it / Need it
Names & contacts for all health professionals	*Recorded in Step 1*	☐ Done / In progress
List of current medications	*Recorded in Step 1*	☐ Done / In progress
School / program information and IPP	*Recorded in Step 1*	☐ Done / In progress
Blank Monthly Calendar (completed)	*Map out a typical month and bring it*	☐ Done / In progress
FCAON Part 1 (FSCD3601)	*Completed with caseworker at meeting*	With worker
FCAON Part 2 (FSCD3602)	*Completed with caseworker at meeting*	With worker
Individualized Family Support Plan / IFSP (FSCD3593)	*Completed with caseworker — Step 4 prepares you*	With worker
FSCD Agreement (FSCD1621)	*Sent to you after approval — sign and return promptly*	With worker
Request for Dental and Orthodontic Support	*If applicable — form included in this package*	If applicable
Notice of Appeal	*Only if disputing a decision — included in package*	If needed
Most recent tax return (line 23600)	*Required if requesting health benefits*	If applicable

You Are Ready When:

☐ Every section of this workbook is filled in as completely as possible
☐ You have gathered your child's medical documentation
☐ You have completed the blank monthly calendar
☐ You have reviewed The Menu and marked the services you want to ask about
☐ You have thought through your vision and drafted your top 2–3 goals

MONTH-AT-A-GLANCE BLANK CALENDAR

MONTH ____________________

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Alberta

Consent to Release Information

Protected A (when completed)

Instructions for Completing the form

To populate the consent form, use the following instructions.

- Select the program the individual is applying to and/or receives supports from.
- Type in the full legal name of the individual (e.g. Melinda May Jones).
- Enter the date of birth for the individual.
- Use drop-down menu to select the type of information being disclose (personal or health information).
- Use drop-down menu to select the authorizing legislation based on the choice selected in field above.
- Specify the type of information that will be disclosed (description of information, relevant dates, etc.).
- Enter the name(s) of the public body (bodies) and/or custodian(s) disclosing the information (where the information is coming from).
- Indicate the name(s) of the organization(s) who will receive (collect) the information. Identify the organization's name so appropriate staff can use the needed information.
- Describe what, why and how the information will be used.
- Use the calendar pop-up to select the effective and expiry dates.
- The individual or authorized representative will need to sign. Before having the individual or authorized representative sign the form, confirm that they:
  - Understand the purpose for disclosing the information.
  - Are aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of the information.
  - Can revoke the consent in writing or electronically at any time
- If the authorized representative is signing on behalf of the individual, also have the authorized representative print their full name.
- Indicate the authorized representative's relationship to the individual.
- Use the drop-down menu to identify the authorizing legislation for the representative to act on behalf of the individual.

Authorized Representatives:

Authorized representatives have the legal authority to exercise an individual's rights under the *Protection of Privacy Act* (POPA) and the *Health Information Act* (HIA) on their behalf. These rights may include consenting to the disclosure of personal and/or health information. This portion of the form should only be filled out if the individual has an authorized representative in place that is responsible for exercising the individual's rights and powers under POPA and the HIA.

Authorized representatives as per POPA and HIA include but are not limited to:

- Guardian of the individual under 18 years of age as per POPA s.54(1)(e) and HIA s.104(1)(c).
- Guardian/trustee appointed for the adult individual (client) under the *Adult Guardianship and Trustee Act* as per POPA s.54(1)(b) and HIA s.104(1)(e).
- An Agent of the individual (client) as designated under the *Personal Directives Act* as per POPA s.54(1)(c) and HIA s.104(1)(f).
- Individual who has been granted the power of attorney as per POPA s.54(1)(d) and HIA s.104(1)(g).
- Individual with written authorization from the individual (client) to act on their behalf as per POPA s.54(1)(f) and HIA s.104(1)(i).

References

Information sharing definitions, education and resources: https://www.alberta.ca/information-sharing.aspx

Alberta

Consent to Release Information

Protected A (when completed)

The personal information you provide is being collected to determine your eligibility for different social-based supports and benefits offered by the Government of Alberta. The personal information you provided to Alberta Supports is collected, used, and disclosed under the authority of the *Protection of Privacy Act* (POPA). To see the list of the programs, including the legislation authorizing each program, you can click Authorizing Legislation.

Questions

If you have questions about the collection or use of your personal information, please contact the Alberta Supports Contact Centre at 1-877-644-9992 (toll free) or 780-644-9992 (Edmonton).

Program(s) I am applying to/receive benefits from:

- ☐ Assured Income for the Severely Handicapped (AISH)
- ☐ Family Support for Children with Disabilities (FSCD)
- ☐ Persons with Developmental Disabilities (PDD)
- ☐ Career and Employment Information Services
- ☐ Child Support Services
- ☐ Disability Related Employment Supports (DRES)
- ☐ Income Support (IS)
- ☐ Residential Access Modification Program (RAMP)
- ☐ Alberta Adult Health Benefits
- ☐ Alberta Child Health Benefits

My name is ____________ ____________ ____________ ____________.

first name | middle name | last name | date of birth yyyy-mm-dd

☐ I am consenting to release my own information

☐ I am consenting to release information about ____________________

name of individual

Information being disclosed is (e.g. personal, health)

Authorized by

To be disclosed by (name(s) of person(s) and/or organization(s))

I give permission to disclose the following personal and/or health information

To be disclosed to (name(s) of person(s) and/or organization(s))

For the following reason(s)

I understand why I have been asked to disclose my information and I am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my information. I understand that I may revoke this consent in writing at any time.

Effective Date yyyy-mm-dd	Expiry Date yyyy-mm-dd

*If you are signing on behalf of the individual, the following must be provided:

name of authorized representative

relationship to individual

Source of representative's authority

Signature of Individual/Authorized Representative

Alberta

Exceptional Consideration Authorization

Protected B (when completed)

Family Support for Children with Disabilities (FSCD)

Child's Name

Child's FSCD File ID

DS Office

Worker

Completed Intake Date yyyy-mm-dd

Based on the Completed Intake Date, Exceptional Consideration is available.

Up to 5 days back preceding completed intake From ____________ Date yyyy-mm-dd

Up to 30 days forward from completed intake To ____________ Date yyyy-mm-dd

The following criteria must **all** be met in order to provide immediate medical management services by Exceptional Consideration:

- ☐ Eligibility for the program must be determined or there must be sufficient information gathered to determine eligibility on an interim basis pending a more thorough assessment of need;
- ☐ The need is directly related to child's disability;
- ☐ No other resource available to meet the immediate need;
- ☐ Child hospitalized outside of home Regional Health Authority;
- ☐ Inpatient hospital stay of 2 or more consecutive days;
- ☐ Overnight accommodation required; and
- ☐ The need for service(s) is urgent and the family's circumstances are such that it would not be appropriate to wait for the completion of a thorough assessment of need and draft agreement as per the service approval policy.

	Unit	Rate	Effective Dates yyyy-mm-dd	
			From	To
Parking				
Mileage				
Public Transportation				
Meals				
Accommodation				
Sibling Care				

Rationale for Request

Decision ◯ Approved ◯ Not Approved

Rationale for Decision

Date yyyy-mm-dd ______ FSCD Caseworker Signature ______

Date yyyy-mm-dd ______ Manager / Supervisor Signature ______

Date yyyy-mm-dd ______ Parent Signature ______

Request for Dental and Orthodontic Treatment Assistance

Protected A (when completed)

The personal information provided is collected under the authority of the *Family Support for Children with Disabilities Act* and Section 4(a) and (c) of the *Protection of Privacy (POPA) Act.* Health information may be shared with Alberta Blue Cross under the authority of section 24 of the *Health Information Act.* This information will be used to determine your child's eligibility for dental/orthodontic treatment assistance. If you require assistance completing this form or have any questions about the collection or use of your personal information please contact your FSCD caseworker.

IMPORTANT NOTICE WHEN COMPLETING THIS FORM

The need for dental care is typical for any child. The FSCD program **may assist with a portion** of dental and orthodontic treatment costs if the need for the treatment is **directly related to the child's disability**, the treatment has been **authorized by Alberta Blue Cross** and the **disability related costs exceed** what is covered by the parent/guardian's dental insurance, benefit plans or any other program or source. Under the FSCD program, if a client does not have private dental insurance, then a $250.00 deductible will be reduced from the first claim payment in each calendar year.

A review is required for **all** dental and orthodontic treatment assistance requests. Alberta Blue Cross determines if the dental and orthodontic treatment requested is disability related in accordance with Schedule D. The Alberta Blue Cross review will determine which dental procedures are related to your child's disability. This means that **some of the work your child needs may be eligible for FSCD support and some may not**. The services that are eligible for FSCD support will be fully covered and you will not be requested to pay for any portion of them. Any authorized treatment will hold for 12 months and treatment **must** be completed prior to the child's 18th birthday.

Steps for completing this form:

Step 1: To be completed by the **FSCD Caseworker**. Filling out this section confirms that the child is eligible for the FSCD program and is eligible for Child Focused Services.

Step 2: To be completed by the **Parent/Guardian**. Please describe the child's habits at home that may impact dental or orthodontic treatment and care.

Step 3: To be completed by the **Parent/Guardian**. When including information about your Health and Dental Benefits coverage, if you receive benefits from another government program, please note the program.

Step 4: To be completed by the **Dental/Orthodontic Treatment Provider**.

Next Steps

After the ABC review is complete, the treatment provider will be notified in writing. The FSCD Caseworker will also receive a copy of the notification. Payments will be made directly to the treatment provider and cannot be made to the parent/guardian.

If there are questions or concerns about the outcome of Alberta Blue Cross' review, the dental or orthodontic treatment provider can contact an Alberta Blue Cross Dental Services call centre representative at 780-498-8977 (Edmonton and area), 403-294-4042 (Calgary and area) or 1-800-567-8104 (toll-free).

FSCD recipients can contact their dental or orthodontic treatment provider if they have any questions about the results of the review.

Step 1 To be completed by the FSCD Caseworker

FSCD Caseworker Last Name

FSCD Caseworker First Name

FSCD Child ID Number

Child Last Name

Child First Name

Child's Diagnosis

☐ By checking this box the FSCD Caseworker is confirming that the child who is the subject of this form has an open file and is eligible for the FSCD program **and** Child Focused Services.

Date yyyy-mm-dd

Step 2 To be completed by the Parent/Guardian

Please provide disability related information about the child's tooth brushing habits, eating habits, and behavioural tendencies that may impact dental care, or any information you believe may help:

Step 3 To be completed by the Parent/Guardian

Note: When including information about your Health and Dental Benefits coverage, if you receive benefits from another government program, please note the program.

Child Last Name

Child First Name

Child's Date of Birth: Year Month Day

I have dental insurance and/or a government benefit plan ◯ Yes ◯ No

Name of Insurance Company (dental, orthodontic benefits or health spending account) OR Government Program	Does this Insurance or Government Program include coverage for dental and/or orthodontic
	◯ Yes ◯ No
	◯ Yes ◯ No

Parent/Guardian Last Name

Parent/Guardian First Name

☐ I hereby acknowledge that I have read and understand the Request for Dental and Orthodontic Treatment Assistance form in its entirety, and I consent to sharing this information with my child's treatment provider and Alberta Blue Cross for the purpose of determining eligibility for FSCD dental/orthodontic treatment assistance.

Date yyyy-mm-dd

Parent/Guardian: Once Steps 1, 2, and 3 are completed, take this form to your child's treatment provider.

Step 4 To be completed by the Dental/Orthodontic treatment provider

A review is required for all dental and orthodontic treatment assistance requests.

The FSCD program cannot commit to any funding prior to the Alberta Blue Cross' recommendation. **Any services or treatment received prior to approval risks not being funded**. Any recommended treatment **must** be completed prior to the child's 18th birthday.

When completing this form, please **do not include any aspect of the child's dental/orthodontic procedures or treatment which would be considered routine**. Any requests for procedures outside of Schedule "D" require review and consideration for exception by Alberta Blue Cross.

Examples where disabilities may cause additional dental or orthodontic expenses are listed below:

- Disabilities with direct involvement
- Disabilities complicating dentistry
- Special cases which require preventative care at more frequent intervals
- Disabilities with minimum dental involvement
- Disabilities creating management problems

Please describe the relationship between the child's disability and the need for the dental or orthodontic treatment that is being proposed. Please attach a claim form and supporting documentation including timeframe, and identify the specific procedure codes and related costs that are directly related to the child's disability:

Treatment Provider's Last Name	Treatment Provider's First Name	Provider ID (PRAC ID)

Treatment Provider's Business Address	City or Town	Province	Postal Code

☐ By checking this box, the treatment provider is acknowledging that the need for the outlined specific dental and orthodontic treatment is **directly related to the child's disability**.

Date yyyy-mm-dd

Upon completion of Step 4, the dental or orthodontic treatment provider will submit this form, treatment plan and other supporting documentation to Alberta Blue Cross by signing into the Alberta Blue Cross dental provider website (http://provider.ab.bluecross.ca/dental).

It is the responsibility of the treatment provider to ensure that Alberta Blue Cross receives adequate information to make a review decision.

Alberta Blue Cross will notify the treatment provider of their decision. The dental treatment provider will be paid for disability related treatment as outlined in Schedule "D". Please note that no payments can be made directly by Alberta Blue Cross to the parent/guardian and a provider shall not bill or seek additional fees from (balance bill or extra bill) the parent/guardian.

Alberta

Request for Mediation of a PDD or FSCD Decision

Protected B (when completed)

Persons with Developmental Disabilities Program or
Family Support for Children with Disabilities

Mediation is a voluntary process which provides an opportunity to resolve an Individual's concern or disagreement with a decision of the Persons with Developmental Disabilities (PDD) or Family Support for Children with Disabilities (FSCD) program in a collaborative way through the use of a neutral, independent, qualified third party mediator. The mediator facilitates a process that may enable a mutually satisfactory resolution through open communication and creative problem solving.

Directions for Requesting Mediation:

- If you choose to go to mediation, a Request for Mediation form must be submitted to the local DS office within 30 calendar days from the day you were notified in writing of the decision.
- Provide a copy of the completed Request for Mediation to your assigned PDD or FSCD caseworker.
- If at the end of the mediation, you are still not satisfied with the outcome, you have the option to appeal. If you require any additional information about the process of appeal please contact the Appeals Secretariat at 780-427-2709.

1 Contact Information

My name is ____________________ .

My phone number is __________ . My work number is __________ . My cell number is __________ .

My address is ____________________ .

My city is __________ . My province is Alberta . My postal code is __________ .

2 Person Requesting Mediation

I am

- ◯ the parent/guardian of ____________________
  a child who has been affected by a decision of the DS director.
- ◯ a person who has been affected by a decision of the DS director.
- ◯ the guardian under the *Adult Guardianship and Trusteeship Act* of ____________________
  who is a person who has been affected by a decision of the DS director.
- ◯ a supporter of ____________________
  who has been affected by a decision of the DS director.
- ◯ co-decision maker of ____________________
  who has been affected by a decision of the DS director.

3 Decision to be Mediated

The decision I am requesting mediation for is:

I received the decision on this date yyyy-mm-dd: __________ .

My reasons for requesting mediation are:

The date of my request is: __________ .
yyyy-mm-dd

Directions for requesting a Review:

1. If you would like an FSCD decision reviewed, please fill out the attached form.
   NOTE: You have 30 calendar days from the date of the decision to submit this form.
2. Please be clear as possible about the decision you would like reviewed. See examples below.
3. Please return the completed form to the Family Support for Children with Disabilities office in your region within the 30 calendar day timeline. You may wish to make a copy for yourself or have your FSCD caseworker make a copy for you.
4. At least two senior staff will review the decision and notify you in writing of the results within 25 calendar days of receiving this request.
5. Please be aware that you may pursue any of the other Concerns Resolution options at the same time.

Examples of decisions that can be reviewed:

- Eligibility for the FSCD program.
- Cancellation of my FSCD agreement.
- A decision relating to an FSCD service.

For more information about the FSCD Program, including the Concerns Resolution options, visit alberta.ca/fscd.

1. I am a Parent/Guardian of the Child named ____________,

Born Year ____ Month ____ Day ____

My Name is ____________

My Address	City or Town	Province	Postal Code
		AB	

Home Phone Number	Cellular Phone Number	Work Phone Number	Other Phone Number

Request for Review

I have been affected by a decision of the Family Support for Children with Disabilities program.

I was told about the decision on Date yyyy-mm-dd ____________ I requested this review on Date yyyy-mm-dd ____________

The decision I want to have reviewed and why is:

For Office Use Only

Request Received By	Date yyyy-mm-dd	Child's File ID#	Worksite Name

NOTICE OF APPEAL FORM

Please complete this form to initiate an appeal of a director's decision under the following programs:

- Assured Income for the Severely Handicapped (AISH)
- Income Support (IS)
- Alberta Child Health Benefit (ACHB)
- Alberta Adult Health Benefit (AAHB)
- Family Support for Children with Disabilities (FSCD)

Not all director decisions are appealable.

Who can appeal?

For the AISH, IS, ACHB or AAHB programs, you can appeal if you have been affected by a decision of a director of the program.

For decisions under the FSCD program, you can appeal if you are a guardian under Part 2 of the *Family Law Act* or under an agreement or order under the *Child Youth and Family Enhancement Act.* A guardian may appeal a decision of a director made under section 3(1)(b) , 4 or 5(1) of the *Family Support for Children with Disabilities Act.*

Time limit to appeal

A director's decision under the AISH, IS, ACHB, or AAHB program may be appealed within 30 days of receiving a verbal or written notice of the decision and the right to appeal.

A director's decision under the FSCD program may be appealed within 45 days of receiving notice of the decision.

Where to send your Appeal

AISH and IS appeals can be submitted to your local Alberta Supports Office or via email to alss.appeals@gov.ab.ca

ACHB and AAHB appeals can be submitted to the office address listed on the letter that advised you of the director's decision.

FSCD appeals can be submitted to your local FSCD office or via email to alss.appealssec-pdd-fscd@gov.ab.ca

All appeal types can be submitted to the Appeals Secretariat via email to alss.appeals@gov.ab.ca, or fax to 780-422-1088 or mail to 2nd Floor, Agronomy Center, 6903 116 Street NW Edmonton AB T6H 5Z2

Appealing a decision under the AISH program

As per section 5(1.1) of the AISH Applications and Appeals (Ministerial) Regulation, the Citizen's Appeal Panel cannot consider any information that has not already been considered by the AISH program. If you have new information or are waiting for documents, please contact the AISH office you have been dealing with so that they can consider your new information before you file an appeal.

Appeal Process

The Appeals Secretariat is a neutral government office that is separate from the AISH, IS, ACHB, AAHB, and FSCD programs. It administers the appeal process by providing administrative support to parties of an appeal and the Citizen's Appeal Panel (i.e., explaining the appeals process, scheduling and confirming hearings.)

Your Notice of Appeal will be shared with the program whose decision you are appealing. They may contact you upon receipt of the Notice of Appeal.

For more information about the appeal process, contact the Appeals Secretariat at 780-427-2709 or alss.appeals@gov.ab.ca

Alberta

Notice of Appeal

Protected B (when completed)

Any personal information you provide on this form is collected, used and disclosed only for the purpose of your appeal, in accordance with sections 4(c), 12(1)(a) and 13(1)(k) of the *Protection of Privacy Act*. For questions about the collection of personal information, contact the Appeals Secretariat at 780-427-2709 or by email as alss.appeals@gov.ab.ca or mail to 2nd floor, Agronomy Centre 6903 116 Street NW, Edmonton, Alberta T6H 5Z2.

Program Decision to be Appealed

◯ Assured Income for the Severely Handicapped (AISH)

◯ Income Support (IS)

◯ Alberta Child Health Benefit (ACHB)

◯ Alberta Adult Health Benefit (AAHB)

◯ Family Support for Children with Disabilities (FSCD)

Appellant Contact Information

Last Name ______ First Name ______ Date of Birth: Year ______ Month ______ Day ______

Mailing Address ______ City or Town ______ Province ______ Postal Code ______

Phone ______ Email Address ______

Decision Being Appealed and Reason for Appealing

What decision are you appealing and why are you appealing the decision? Please include the program file number, and if you received the decision in writing, please attach a copy.

What date did you receive the director's decision and notification of your right to appeal (verbal or written)?

______
Date yyyy-mm-dd

If you are submitting an appeal past the time limit (within 30 days of being notified of the AISH/IS/ACHB/AAHB decision OR 45 days from the date of the FSCD decision), please explain why.

Accommodations Required

Do you need an interpreter or any other accommodation to be able to participate in the appeal process? (i.e., ASL, advocate, document translation)

◯ Yes ◯ No

Please indicate the accommodation needed

Additional Information

Provide any additional information relating to your appeal.

Printed Name | Date yyyy-mm-dd | Signature