# THERAPEUTIC PRESCHOOL THERAPY SERVICES

Scope of Service

## Program Purpose

- To provide evaluation, intervention, education and parent training to children from birth through 10 years of age, who demonstrate rehabilitation needs due to a physical, cognitive or developmental impairment.
- The program goal is to aid the child in achieving their highest level of function in self-care activities, motor development, mobility, communication, cognition, & preschool activities.
- The family/caregiver(s) are integral members of their child's rehabilitation team. Parental involvement in developing goals, carrying through home programs and preparing for school integration is encouraged and facilitated.

## Population(s) Served

Children referred for outpatient or preschool services demonstrate a variety of rehabilitation needs on admission. They may include, but are not limited to, one or more of the following:

- Mobility impairments
- Fine and gross motor impairments
- Visual perceptual and/or visual motor impairments
- Communication and/or cognitive impairments
- Feeding concerns
- Sensory integration needs
- Functional impairments

## Hours/Frequency of Services

- Services are offered at our Children's Center Campus, 3101 Main Street, Kansas City, MO.
- Outpatient services are offered between 7:30 AM – 5:30 PM, Monday through Friday.
- Services are determined based on medical need. Frequency of service is determined by evaluation, physician recommendation, and ability to access services. Frequency of service is discussed after evaluation.

## Funding Sources

Services are funded by a variety of sources which may include but are not limited to:

- Commercial Insurance
- Medicaid
- Self-pay – fees can be discussed, at time of referral, with business office
- Other funding sources (Cerner Charitable Foundation, Clay County Children's Fund, Caring Program, Charity)

## Program/Services Offered

The Team consists of the child, their family and professionals, as appropriate, from the specialties of:

- ABA services (BCBA/RBT)
- Assistive Technology
- Aquatics
- Case Management
- Education Specialist
- Neuropsychology/Psychology
- Nursing
- Occupational Therapy
- Patient Representative
- Physiatry
- Physical Therapy
- Social Work
- Speech and Language Pathology

## Referral Procedures

Referrals to the programs may be made directly by family members, physicians, school personnel, and others in the community.

Referrals are initiated by contacting the program case manager.

A written prescription for treatment from the physician is required. This must come from a M.D. or D.O.

Consulting services are available upon referral in the following areas:

- Audiology
- Dentistry
- Durable medical equipment
- Neurology
- Nutrition
- Ophthalmology/optometry
- Orthotics/prosthetics
- Primary care physician
- Resources for spiritual needs
- Swallow assessments
- Other resources as identified by treatment team

## Program Admission Criteria

For admission, the patient must:

- Have a developmental disability or an illness or injury resulting in a change or delay in their functional daily activity status;
- Have a reasonable expectation for greater functional independence and the ability to achieve goals and show progress;
- Have the potential to comprehend and cooperate with the plan of care; and be medically stable.
- There are no restrictions placed on acceptance of children, and every attempt is made to meet the needs of the child and their family in relation to geographic location, age, sex, race, culture, sexual orientation, gender identity or financial status.
- For those who do not live in the greater metropolitan area, assistance to locate housing is available.
- Children diagnosed with childhood communicable diseases and/or tuberculosis are not admitted for rehabilitation services.
- Persons are not admitted for psychiatric care.
- Individuals with behavioral issues related to physical or neurological impairment will be admitted if it is determined the program can effectively manage in this environment.

## Discharge Planning & Criteria

- Discharge planning begins upon admission to the program with child, family, staff and community agency participation as appropriate.
- The case manager, with support from the therapy team, facilitates and coordinates discharge planning and the transfer of information to school, physician, other agencies, etc.
- Family conferences and home visits are scheduled as necessary and may be an integral part of discharge planning.
- Projected discharge dates are established with child/family/caregiver and the treatment team in accordance with goal achievement.
- Referrals are made to other community agencies during program and upon completion of the program.

- Discharge planning and decisions consider the following:
    - Child, family/caregivers and support system's preferences, needs and resources
    - Child's ability to be functional in the home, school and/or community environment
    - Progress toward achievement of program goals
    - Child's potential to continue to progress
    - Child or family/caregiver's desire to receive or obtain alternative services
    - Compliance with organizational policies
    - Need for further health-care intervention

## Intended Discharge Environment

The Program prepares the child who is already living in a home setting with support to be more independent in the home, school and community

## Follow-Up Services

Follow- up is completed by phone call 90 days and one year after discharge.

Families are encouraged to contact case manager or therapy team if concerns arise.

## Expected Program Outcome

The child will be more independent at home and in school and the community.