

Wraparound Integrity Tool

Version 2.0

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Time 1/Baseline Collected no later than 30 days from referral and before first meeting	Time 2 Collected at a maximum of once a month from the point of initial assessment to a minimum of once at three months after initial assessment, or before school year ends	Time 3 Collected at a maximum of once a month from the point of Time 2 assessment to a minimum of once at six months after initial assessment, or before school year ends	Time 4 Collected at a maximum of once a month from the point of Time 3 assessment to a minimum of once at nine months after initial assessment, or before school year ends
--	--	---	--

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

- 1) Date Tool Completed: _____
- 2) Today's date: _____
- 3) Tool filled out by: Individual Team
- 4) Role(s) of team member(s) involved in rating the integrity of wraparound (choose all that apply):
 Family/Caregiver Team Facilitator Teacher/School Representative Youth Other

Ask this question with Family at Baseline:

- 5) Please indicate all previous school behavior intervention related meeting(s) attended that reflect the baseline rating:
 IEP Meeting Suspension Manifestation Determination Meeting
 Intervention Planning Meeting Parent/school conference Not baseline assessment
 Other: Please Define: _____

Definitions:

<p>In Place = Perceived to be 81-100% in place</p> <p>Mostly in Place = Perceived to be 61-80% in place</p> <p>Somewhat in Place = Perceived to be 41-60% in place</p>	<p>Minimally in Place = Perceived to be 21-40% in place</p> <p>Not at all in Place = Perceived to be 0-20% in place</p> <p>N/A = Not Applicable</p>
---	--

Current Status (Perceived status of the action step as of the day the rating takes place)						Phase I: Engagement & Team Preparation
In Place (5)	Mostly in Place (4)	Somewhat in Place (3)	Minimally in Place (2)	Not at all in Place (1)	N/A	
						6) Met with family to gather their perspective & position
						7) Met with key team members to gather various perspectives
						8) Generated a strengths list (multiple settings & perspectives)
						9) Generated a team member list with the family
						10) Team member list includes natural supports
						11) Scheduled an initial Child/Youth & Family Team meeting with the family

Current Status (Perceived status of the action step as of the day the rating takes place)						Phase II: Initial Plan Development
In Place (5)	Mostly in place (4)	Somewhat in Place (3)	Minimally in place (2)	Not in place (1)	N/A	
						12) Baseline data about strengths/needs documented and shared
						13) One or two Child/Youth & Family Team Meetings have taken place
						14) Data is collected from team members on an ongoing basis
						15) Data-based decision-making is integrated into the team process
						16) Strengths (home/school/community) were documented & reviewed at meetings
						17) Needs (home/school/community) were documented & reviewed at meetings
						18) Reviewed family concerns as well as school concerns
						19) Reviewed needs that reflect a consensus of team member concerns
						20) Chose a few needs for team to focus action planning on
						21) Assigned special priority to family concerns
						22) 100% of chosen methods matched to child & family strengths
						23) Methods chosen reflect voice/choice of those involved in implementing (i.e., family, teacher, etc.)
						24) Developed function-based positive behavior support plans to address problem behaviors related to priority needs
						25) Behavior plans include clear outcomes/behaviors to establish: teaching, practice, reinforcement strategies/timelines
						26) Community resources are being accessed as needed to meet needs identified by family

Current Status (Perceived status of the action step as of the day the rating takes place)						Phase III: Plan Implementation & Refinement
In Place (5)	Mostly in Place (4)	Somewhat in Place (3)	Minimally in Place (2)	Not at all in Place (1)	N/A	
						27) Accomplishments of student & team are being documented
						28) Team members are following through with activities, including function-based positive behavior support plans, at home, school, and community
						29) Assessment of the plan is occurring on an ongoing basis
						30) Team is meeting often enough to check follow through and assess progress
						31) Family is regularly asked if actions provided meet needs
						32) Behavioral and academic data is regularly reviewed to identify progress and determine next steps
						33) Adjustment of the plan is occurring based on family and team feedback including responsibilities for tasks
						34) Team members receive regular documentation including data and plan updates
						35) Plan includes interventions that occur in home, school, and community
						36) Crisis contingencies are negotiated and practiced in home, school, and community as needed
						37) Communication occurs among those providing interventions in home, school, and community
Current Status (Perceived status of the action step as of the day the rating takes place)						Phase IV: Transition
In Place (5)	Mostly in Place (4)	Somewhat in Place (3)	Minimally in Place (2)	Not at all in Place (1)	N/A	
						38) Transitioning out of Wraparound has been discussed with the whole team
						39) Concerns of all team members have been considered in transition planning
						40) Family is provided with a list of team member phone numbers who can be contacted if needed
						41) Methods for future access to services are communicated to all team members
						42) Family receives written documents highlighting their strengths & team accomplishments
						43) Methods of introducing student and family to future teachers or providers are negotiated
						44) Family has been given an opportunity to meet/interact with other families who have been through the process

Student Disposition Tool

Version 2.0

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Note: Facilitator is REQUIRED to complete this tool at EVERY ASSESSMENT

Time 1/Baseline	Time 2	Time 3	Time 4
Collected no later than 30 days from referral and before first meeting	Collected anywhere from a maximum of monthly from the point of initial assessment to a minimum of once at three months following initial assessment, or before the school year ends	Collected anywhere from a maximum of monthly from the point of Time 2 assessment to a minimum of once at six months following initial assessment, or before the school year ends	Collected anywhere from a maximum of monthly from the point of Time 3 assessment to a minimum of once at 9 months after initial meeting, or before the school year ends

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

1) Date Tool Completed: _____

2) Has educational placement changed in the past three months? Yes No

3) If yes, please identify the **new educational placement** (If yes, also update student enrollment page of SIMEO II):

- General ed. classroom 100% of the day-FACTS Code 01
- General ed. classroom with special ed. consultation-FACTS Code 01
- General ed. classroom with inclusion support-FACTS Code 01
- Special ed. instruction and/or related services 1-20% of the day OUTSIDE the general ed. classroom-FACTS Code 01
- Special ed. instruction and/or related services 21-60% of the day OUTSIDE the general ed. classroom-FACTS Code 02
- Special ed. instruction and/or related services more than 60% of the day OUTSIDE general ed.-FACTS Code 03
- Special ed. 100% in a separate public day school-FACTS Code 04
- Special ed. 100% in a separate public day school in conjunction with a separate residential component-FACTS Code 05
- County or municipal detention center or jail-FACTS Code 07
- IYC – Jail-FACTS Code 07
- Private day school-FACTS Code 08
- Private residential-FACTS Code 09
- Alternative education setting
- Homebound-FACTS Code 11
- Hospital-FACTS Code 12
- Regular education Pre-school
- Special education Pre-school/Early Childhood
- Community Child Care
- Partial day school
- Education Placement did not change

4) Are there other agencies currently involved with the student and/or family? Yes No

5) If yes, indicate agencies currently involved:

- DCFS Probation Mental Health Public Aid Other: _____ Not applicable

6) Does this student have DCFS legal involvement? Yes No

7) How many student/family team meetings were held since last SIMEO review or assessment, to include baseline? _____

8) Were SWIS data used in any student/family meetings during the reporting period? Yes No

9) Were SIMEO data used in any student/family meetings during the reporting period? Yes No

10) If yes, please indicate how data were used (check as many as apply):

- To engage team members To ensure voice of family To design interventions
 To revise actions of team To celebrate success Data not used

11) School attendance: 59% or below 60-69% 70-79% 80-89% 90-100%

12) Please rate the approximate Grade Point Average of the student:

- 59% or below 60-69% 70-79% 80-89% 90-100% Not applicable

13) Risk of failure in home placement: No risk Minimal risk Moderate risk High risk

14) Risk of failure in school placement: No risk Minimal risk Moderate risk High risk

15) Risk of failure in community placement: No risk Minimal risk Moderate risk High risk

16) How many office disciplinary referrals in the past three months? _____

17) How many in-school suspensions in the past three months? _____

18) How many out-of-school suspensions in the past three months? _____

19) Has the student been expelled in the past three months? Yes No

20-22. Check if services are currently being utilized (Complete at all assessment periods)

20) Home Environment

- | | | |
|---|---|--|
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Parent Supports |
| <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Housing Assistance | <input type="checkbox"/> Pre-natal Care |
| <input type="checkbox"/> Counseling - Couples | <input type="checkbox"/> In-Home Services | <input type="checkbox"/> Public Aid/TANF |
| <input type="checkbox"/> Counseling - Group | <input type="checkbox"/> Individual Aide | <input type="checkbox"/> Recreation Plan |
| <input type="checkbox"/> Counseling - Individual | <input type="checkbox"/> Medical Services | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Counseling – Substance Abuse | <input type="checkbox"/> Medication | <input type="checkbox"/> Service Coord./Case Mgmt. |
| <input type="checkbox"/> Domestic Violence Intervention | <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Employment Assistance | <input type="checkbox"/> Mental Health Assessment | <input type="checkbox"/> Vocational Training |
| <input type="checkbox"/> Financial Support | <input type="checkbox"/> Mentoring | <input type="checkbox"/> Personal Assistant |
| <input type="checkbox"/> Homemaking Services | <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Other: _____ |

21) School Environment

- | | | |
|--|---|--|
| <input type="checkbox"/> Academic Interventions | <input type="checkbox"/> FBA/BIP | <input type="checkbox"/> Special Education Referral |
| <input type="checkbox"/> Academic Tutoring | <input type="checkbox"/> Medication | <input type="checkbox"/> Speech and Language Therapy |
| <input type="checkbox"/> After School Program | <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Anger Management Interventions | <input type="checkbox"/> Mentor/Advocate | <input type="checkbox"/> Summer School Program-Not part of IEP |
| <input type="checkbox"/> Case Management Services | <input type="checkbox"/> Personal Assistant/Aide or Individual Aide | <input type="checkbox"/> Transition Planning |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Peer Mentor | <input type="checkbox"/> Vocational Assessment |
| <input type="checkbox"/> Counseling - Group | <input type="checkbox"/> Peer Support Strategies | <input type="checkbox"/> Vocational/Post-Secondary Planning |
| <input type="checkbox"/> Counseling - Individual | <input type="checkbox"/> Nursing Care | <input type="checkbox"/> ESY-As part of IEP |
| <input type="checkbox"/> Crisis/Safety Plan | <input type="checkbox"/> Relaxation & Self-Modulation Training | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Curriculum Modification | <input type="checkbox"/> Social Skills Instruction | _____ |
| <input type="checkbox"/> Discrete Trial Format or Applied Behavioral Analysis teaching | | _____ |

22) Community Environment

- | | |
|--|---|
| <input type="checkbox"/> After School Programming | <input type="checkbox"/> Peer Mentor |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Recreation Services |
| <input type="checkbox"/> Community Mentoring | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Cultural/Spiritual Supports | <input type="checkbox"/> Youth Support Groups |
| <input type="checkbox"/> Employment Assistance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Outward Bound Experience | _____ |

Home, School, Community Tool Version 2.1

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Time 1/Baseline	Time 2	Time 3	Time 4
Collected no later than 30 days from referral and before first meeting	Collected at a maximum of once a month from the point of initial assessment to a minimum of once at three months after initial assessment, or before school year ends	Collected at a maximum of once a month from the point of Time 2 assessment to a minimum of once at six months after initial assessment, or before school year ends	Collected at a maximum of once a month from the point of Time 3 assessment to a minimum of once at nine months after initial assessment, or before school year ends

- How to complete this form:**
- Answers to the survey should reflect the team's experience over the past month or past three months, depending on frequency of assessment
 - Youth's facilitator and parent or caregiver completes the form together during the initial conversation or the initial child and family meeting
 - Youth's school teacher is asked to provide input for completing school section of needs and strengths

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

1) Date Tool Completed: _____

2) Who filled out this tool: Individual Team

3) If an individual, indicate role:

- Parent/Caregiver
 Teacher
 ISTAC Coordinator
 Wrap Facilitator
 Family Focus Facilitator-Autism
 PBIS Coach
 Other (*please specify*): _____

Use the following rubric when identifying needs and strengths:

High Need = Student demonstrates significant and/or extreme challenge and need in this area of functioning, potentially leading to failure of the home, school, and/or community placement.

Somewhat Need = Student demonstrates challenge and need in this area of functioning but not enough to warrant failure of home, school, and/or community placement.

Somewhat Strength = Student demonstrates growth and maturation in this area of functioning, and at times still needs guidance and direction.

High Strength = Student demonstrates above average or excellent growth and maturation in this area of functioning requiring no additional guidance or direction.

Needs/Strengths	HOME				SCHOOL				COMMUNITY			
	Need		Strength		Need		Strength		Need		Strength	
	high 1	some- what 2	some- what 3	high 4	high 1	some- what 2	some- what 3	high 4	high 1	some- what 2	some- what 3	high 4
Safety/Medical/Basic Needs												
4) Health does not limit child's activity												
5) Sees a doctor or nurse when needed												
6) Is safe from violence/crime												
7) Has adequate/safe physical environment												
8) Has life/survival skills												
9) Has enough to do (age-appropriate activities)												
10) Has enough to eat (well-balanced meals)												
11) Has transportation												

Needs/Strengths	HOME				SCHOOL				COMMUNITY			
	Need		Strength		Need		Strength		Need		Strength	
	high 1	some- what 2	some- what 3	high 4	high 1	some- what 2	some- what 3	high 4	high 1	some- what 2	some- what 3	high 4
Social Relationships												
12) Has friends												
13) Is accepted by other children												
14) Gets along with children												
15) Gets along with adults												
16) Respects adults in authority												
Emotional Functioning												
17) Controls his/her anger												
18) Feels that he/she belongs												
19) Knows when to ask for help												
20) Knows how to ask for help												
21) Handles disagreements												
22) Responds like other youth to emotional situations												
Behavioral Functioning												
23) Seeks attention in appropriate ways												
24) Follows rules												
25) Controls him/herself												
26) Cares for own personal safety												
27) Participates in activities												
28) Is usually on time												
29) Accomplishes chores/assignments/ jobs/tasks on time												
30) Accomplishes chores/assignments successfully												
31) Pays attention to directions												
32) Works independently												
33) Behaves appropriately in unsupervised settings												
34) Likes to get better at the things he/she does												
Cultural/Spiritual												
35) Cultural needs are met												
36) Spiritual needs are met												
37) Feels accepted												

Educational Information Tool

Version 2.0

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Time 1/Baseline Collected no later than 30 days from referral and before first meeting	Time 2 Collected anywhere from a maximum of monthly from the point of initial assessment to a minimum of once at three months following initial assessment, or before the school year ends	Time 3 Collected anywhere from a maximum of monthly from the point of Time 2 assessment to a minimum of once at six months following initial assessment, or before the school year ends	Time 4 Collected anywhere from a maximum of monthly from the point of Time 3 assessment to a minimum of once at 9 months after initial meeting, or before the school year ends
--	--	---	--

How to complete this tool:

- Classroom teacher or lead teacher for student completes the tool
- If more than one teacher is involved in the classroom functioning evaluation, see group scoring options
- Answers to the survey should reflect the teacher(s) experience with youth over the last three months

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

1) Date tool completed: _____

2) This tool was filled out by: An individual teacher A team of teachers

3) Please check if you are a: General Education Teacher Special Education Teacher Focus Family Facilitator
 ISTAC Coach PBIS Coach Other (*please specify*): _____

4) How many months has this student been in your class or classes? _____

5) How well do you know this student? Not Well Moderately Well Very Well

6) Has this student transferred during the past year? Yes No N/A

7) Is this student attending the school they would attend if they did not have a disability? Yes No N/A

CLASSROOM FUNCTIONING:

- Never** = Display of this functional behavior never occurs
- Sometimes** = Display of this functional behavior occurs less than one time per week
- Frequently** = Display of this functional behavior occurs between one to four times a week
- Always** = Display of this functional behavior occurs daily or more than one time per day

SECTION I: (ALL ISTAC PROGRAMS) Based on your expectations of children in your classroom, please indicate the extent to which the above student...	Never	Sometimes	Frequently	Always	Not Applicable
8) Attends school	1	2	3	4	N/A
9) Completes class assignments on time	1	2	3	4	N/A
10) Works independently	1	2	3	4	N/A
11) Completes homework on time	1	2	3	4	N/A
12) Passes quizzes and tests	1	2	3	4	N/A
13) Completes subjects with a passing grade	1	2	3	4	N/A
14) Participates in classroom discussions and activities	1	2	3	4	N/A
15) Pays attention in class	1	2	3	4	N/A

16) Participates in extracurricular activities	1	2	3	4	N/A
17) Has friends	1	2	3	4	N/A
18) Engages in socially appropriate behavior with peers	1	2	3	4	N/A
19) Engages in socially appropriate behavior in unsupervised settings	1	2	3	4	N/A
20) Engages in appropriate classroom behavior with adults	1	2	3	4	N/A
SECTION II	Never	Sometimes	Frequently	Always	Not Applicable
21) Student follows same routine as other students	1	2	3	4	N/A
22) Student participates in lessons that are differentiated for all students throughout the day	1	2	3	4	N/A
23) Student participates with same age peers without disabilities in non-academic classes throughout the school day	1	2	3	4	N/A
24) The student is given individual accommodations to meet his/her learning needs	1	2	3	4	N/A
25) Interaction between student and regular education teacher occurs at frequencies similar to other students in the classroom	1	2	3	4	N/A
26) Student has individual daily schedule visible (if needed)	1	2	3	4	NA
27) Student has a system for communicating with peers and adults, across settings, throughout the school day	1	2	3	4	NA
28) Student's work is monitored for progress and understanding during activities	1	2	3	4	NA
29) Student follows directions independently	1	2	3	4	NA
30) Student follows directions with supports	1	2	3	4	NA
31) Student completes work independently	1	2	3	4	NA
32) Student completes work with supports	1	2	3	4	NA
33) Student transitions between activities and environments independently	1	2	3	4	NA
34) Student transitions between activities and environments with supports	1	2	3	4	NA
SECTION III	Never	Sometimes	Frequently	Always	Not Applicable
35) Student needs academic assistance in excess of the assistance expected with classroom instruction	1	2	3	4	NA
36) This student needs behavioral interventions beyond the classroom routine	1	2	3	4	NA

ACADEMIC PERFORMANCE

37) Has student repeated a grade? Yes No

38) Is student's overall performance commensurate with his/her ability? Yes No

39) Please rate the student's academic performance:

Failing (GPA 0-59%)
 Below Average (GPA 60-69%)
 Average (GPA 70-79%)
 Above Average (GPA 80-89%)
 Superior (GPA 90-100%)

40) Number of students in your class: _____

41) How often is this student in your classroom?

Less than once a week
 Once a week
 2-3 times per week
 50% or less of day
 51-100% of day

Youth Satisfaction Tool Version 2.0

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Time 1/Baseline Collected no later than 30 days from referral and before first meeting	Time 2 Collected 3 months after initial meeting or before school year ends	Time 3 Collected 6 months after initial meeting or before school year ends	Time 4 Collected 9 months after initial meeting or before school year ends
--	--	--	--

How to complete this tool:

- Youth completes the tool
- When completed at baseline, survey is intended to reflect youth's experience with a previous team (if any) such as a special education IEP team
- At time 2, 3, 4, and so forth, survey is intended to reflect youth's experience with his/her current child and family wraparound team

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

1) Date Tool Completed: _____

To what extent have members on your team...	Not at all	Slightly	Some-what	A great deal
2) Included you in the team meetings?	1	2	3	4
3) Included you in decisions?	1	2	3	4
4) Asked you about your needs?	1	2	3	4
5) Treated you with respect?	1	2	3	4
6) Asked you about your strengths?	1	2	3	4
7) Asked you about your family's strengths?	1	2	3	4
8) Asked you about your family's needs?	1	2	3	4
9) Helped you understand how to use your strengths and needs?	1	2	3	4
10) Involved you in activities and programs that were beneficial?	1	2	3	4
11) Increased your ability to get involved with your school?	1	2	3	4

Facilitator Instructions: *Please assist or read to youth who may need help reading or understanding items.*

Family/Caregiver Satisfaction Tool Version 2.0

Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)

Time 1/Baseline Collected no later than 30 days from referral and before first meeting	Time 2 Collected 3 months after initial meeting or before the school year ends	Time 3 Collected 6 months after initial meeting or before the school year ends	Time 4 Collected 9 months after initial meeting or before the school year ends
--	--	--	--

How to complete this tool:

- Parent or caregiver completes the tool
- When completed at baseline, survey is intended to reflect parent or caregiver's experience with a previous team (if any) such as a special education IEP team
- At Time 2,3, 4, and so forth survey is intended to reflect parent or caregiver's experience with the current child and family wraparound team

Student Name: _____ **Student ID:** _____

Please identify the period of assessment:

<input type="checkbox"/> Time 1/Baseline	<input type="checkbox"/> Time 2	<input type="checkbox"/> Time 3	<input type="checkbox"/> Time 4	<input type="checkbox"/> Time 5
<input type="checkbox"/> Time 6	<input type="checkbox"/> Time 7	<input type="checkbox"/> Time 8	<input type="checkbox"/> Time 9	<input type="checkbox"/> Time 10
<input type="checkbox"/> Time 11	<input type="checkbox"/> Time 12	<input type="checkbox"/> Time 13	<input type="checkbox"/> Time 14	<input type="checkbox"/> Time 15
<input type="checkbox"/> Time 16	<input type="checkbox"/> Time 17	<input type="checkbox"/> Time 18	<input type="checkbox"/> Time 19	<input type="checkbox"/> Discharge

1) Date Tool Completed: _____

2) What type of team have you worked with in the past? *(Answer only at baseline)*

- | | |
|---|--|
| <input type="checkbox"/> Child and family wrap team | <input type="checkbox"/> Other agency led team |
| <input type="checkbox"/> Special Ed/IEP team | <input type="checkbox"/> Other school team |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Not applicable |

3) What is your relationship with this child?

- | | |
|---|---|
| <input type="checkbox"/> Biological/adoptive parent | <input type="checkbox"/> Primary childcare worker |
| <input type="checkbox"/> Foster parent | <input type="checkbox"/> Therapist |
| <input type="checkbox"/> Relative | <input type="checkbox"/> Other: _____ |

We are interested in your thoughts about this service/process. Please answer each question as honestly as you can.

To what extent have members on your team provided the following?	Not at all	Slightly	Some-what	A great deal
4) Scheduled meetings at convenient times for you to meet?	1	2	3	4
5) Returned phone calls in a timely manner?	1	2	3	4
6) Included you in decisions about your child and family?	1	2	3	4
7) Asked you about the needs and strengths of your entire family?	1	2	3	4
8) Treated you with respect?	1	2	3	4
9) Improved your family's quality of life overall?	1	2	3	4
10) Improved your ability to care for your child?	1	2	3	4

To what extent have members on your team provided the following?	Not at all	Slightly	Some-what	A great deal
11) Eased your worries about the future well-being of your child?	1	2	3	4
12) Given you information about your community resources?	1	2	3	4
13) Helped you understand your child's strengths?	1	2	3	4
14) Helped you understand your child's needs?	1	2	3	4
15) Helped you understand your family's strengths?	1	2	3	4
16) Helped you understand your family's needs?	1	2	3	4
17) Helped you understand how to use strengths and needs to work with your child?	1	2	3	4
18) Helped you obtain services for your child and family that you were unable to get before?	1	2	3	4
19) Increased your ability to get involved with your child's school?	1	2	3	4
	Very unlikely	Unlikely	Likely	Very likely
20) How likely would you repeat this process if your family needed assistance in the future	1	2	3	4
21) How likely would you recommend this process to a friend?	1	2	3	4

22) If a friend were to ask you about this experience what would you tell him or her?

We appreciate your comments.

Thank you! 😊

Facilitator Instructions: *Please assist or read to respondent who may need help reading or understanding items.*