

LEARNING NEEDS SCREENING

Directions for County Worker:

1. Before asking the questions on this form, give the client form WTW 19 (Learning Needs Screening - Client Copy) so he or she can follow along and read the questions silently as you read them aloud.
2. Before proceeding to the Learning Needs Screening questions on the following pages, read the following preamble aloud to the client:

PREAMBLE:

I am going to ask you questions about your school experiences and your health. Your answers will help me figure out what, if anything, is getting in your way of training and working. Your answers will also help me develop your welfare-to-work plan and help me figure out what services you may need to be successfully employed. It is very important that you answer these questions so that I can determine the right kind of welfare-to-work activities for you, and to get you the help and services you may need to succeed. These questions are not intended to determine the existence of a learning disability. They are only the first step in the evaluation process.

Please keep in mind that most people with learning disabilities are intelligent and many are gifted. Individuals with a learning disability may have difficulty with the following:

- Reading
- Listening
- Understanding directions
- Writing
- Spelling
- Math
- Organizing things
- Getting along with others
- Expressing ideas out loud
- Paying attention

Individuals with a learning disability can be taught to use their strengths and find ways to make it easier to learn and be more successful at school and on the job. I can help individuals get the appropriate welfare-to-work activities, including accommodations once a learning disability is identified.

Please keep in mind this screening is a very simple and short test. It will help you decide if you would like a referral to a learning disability specialist for an evaluation to find out if a learning disability exists. The areas that will be tested at evaluation are the following:

- Natural talents and abilities
- Ability to follow verbal and written information
- Achievement
- Job and Career interests

The specialist can help identify strengths and weaknesses so that we can make referrals to the appropriate services and accommodations for you. Please remember that you have the right to file for a fair hearing if you disagree with a county action including actions related to learning disabilities.

If you are Limited-English proficient and a Learning Needs Screening is not available in your primary language, you have the right to request a referral directly for a learning disabilities evaluation.

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3. **REFUSAL TO BE SCREENED OR EVALUATED:** If the client makes the decision to not be screened, read the WTW 17 form (Waiver of CalWORKs Learning Disabilities Screening and/or Evaluation) to the client and explain the importance and benefits of a learning disabilities screening and/or a learning disabilities evaluation. Do not offer the waiver in lieu of offering the screening or evaluation. If the client still does not want to be screened or evaluated, have the client sign the WTW 17 form. Give a copy of the form to the client and retain the original in the case file.

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Directions for County Worker (Continued):

4. Ask the client each question in sections I, II, III, and IV on page 3.
 - a. Record the client's responses by checking "YES" or "NO."
 - b. Count the number of "YES" responses in each section, then multiply by the number indicated in the section. For example, multiply the number of "YES" responses obtained in Section III by 3. Then enter the result after the equal sign as the subtotal.
 - c. To obtain a total, add the subtotals from sections I, II, III and IV.
 - d. If the total from sections I, II, III and IV is 12 or more, refer the client for a learning disabilities evaluation and document the referral in the case file.
5. Ask the client each of the supplemental questions on page 4 regardless of the score.
 - a. Record the client's responses by checking "YES" or "NO" and filling in the blanks, where appropriate.
 - b. Ask the client to provide any record of a previous learning disabilities evaluation, attendance in special education, or medical conditions. If the client appears to have problems obtaining the information, the county will assist the client. The client will sign the appropriate document to grant permission to obtain the information.
 - c. With the client's written consent (WTW 20: Permission to Release Learning Disabilities Information), forward the records to the learning disabilities evaluator for consideration.
 - d. Refer the client, as appropriate, to a medical or service provider(s) to address any potential health concerns identified on page 4.

Note: The Learning Needs Screening tool is not intended to determine the existence of a learning disability. It is only the first step in the evaluation process.

LEARNING NEEDS SCREENING

CLIENT NAME		COUNTY CASE NUMBER
INTERVIEWER NAME	INTERVIEWER TITLE	INTERVIEW DATE

SECTION I	YES	NO
1. Have you had any problems learning in middle school or junior high?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have difficulty working from a test booklet to an answer sheet?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty or experience problems working with numbers in a column?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have trouble judging distances?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do any family members have learning problems?	<input type="checkbox"/>	<input type="checkbox"/>
Count the number of "YES" answers for Section I _____ X 1 = _____ Subtotal for Section I		

SECTION II	YES	NO
6. Have you had any problems learning in elementary school?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have difficulty or experience problems mixing mathematical signs (+/x)?	<input type="checkbox"/>	<input type="checkbox"/>
Count the number of "YES" answers for Section II _____ X 2 = _____ Subtotal for Section II		

SECTION III	YES	NO
8. Do you have difficulty or experience problems filling out forms?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you experience difficulty memorizing numbers?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have difficulty remembering how to spell simple words you know?	<input type="checkbox"/>	<input type="checkbox"/>
Count the number of "YES" answers for Section III _____ X 3 = _____ Subtotal for Section III		

SECTION IV	YES	NO
11. Do you have difficulty or experience problems taking notes?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have trouble adding or subtracting small numbers in your head?	<input type="checkbox"/>	<input type="checkbox"/>
13. Were you ever in a special program or given extra help in school?	<input type="checkbox"/>	<input type="checkbox"/>
Count the number of "YES" answers for Section IV _____ X 4 = _____ Subtotal for Section IV		

 TOTAL of Sections I through IV: _____

If total is 12 or more, refer for further evaluation. Complete the next page regardless of the score.

LEARNING NEEDS SCREENING (Continued)

EDUCATION:

14. Were you ever in special education classes in school? YES NO
15. Have you ever been diagnosed or told you have Learning Disabilities? YES NO
 If YES, by whom? _____ When? _____
 Type(s) of Learning Disabilities (if known): _____
16. Have you ever been diagnosed or told that you have Attention Deficit Disorder with or without hyperactivity? YES NO
 If YES, by whom? _____ When? _____

GLASSES:

17. Do you need or wear glasses or contact lenses? YES NO
18. Was your last vision test within the last two years? YES NO

HEARING:

19. Do you need or wear a hearing aid? YES NO
20. Have you had your hearing tested in the last 12 months? YES NO

SPEECH:

21. Have you ever seen a speech or language therapist? YES NO

MEDICAL/PHYSICAL:

22. Have you ever had any of the following:
- a lot of ear infections? YES NO
 - a lot of sinus problems? YES NO
 - high fevers that lasted a long time? YES NO
 - diabetes (high blood sugar)? YES NO
 - severe allergies? YES NO
 - a lot of headaches or migraines? YES NO
 - a head injury? YES NO
 - convulsions or seizures? YES NO
 - serious health problems? YES NO
23. Are you taking any medications that affect the way you think, act, or feel? YES NO
 If YES, what are you taking? _____
 How often? _____
24. Do you need medical or follow-up services? YES NO
 County referrals needed/made: _____