Clear Form Data

Arkansas Independent Assessment (ARIA)

Filling this form with Adobe Acrobat

What you need

In order to **fill in and save** the data on this form you need one of the following:

- Adobe Acrobat Standard 7 or higher
- Adobe Acrobat Professional 7 or higher

If you only have Adobe Reader you will be able to fill in but **not** save the form data.

Downloading the form

For access and completion of these forms, you must copy the form(s) onto your hard drive. Do not use the version on the web page for completing and merging.

1. Open one of the forms on the web page
2. Click on the "disc" icon found on the toolbar
3. Save the document to your hard drive.

To fill out a form

1. Open the form (saved on your hard drive) on the following page. Select the Hand tool.
2. Move the cursor inside the first field and click. The I-beam pointer allows you to type text. The arrow pointer allows you to select a button, a check box, a radio button, or an item from a list. After entering text do one of the following:
   - Press *Tab* to go to the next form field to enter data.
   - Press *Shift-Tab* to go to the previous form field.
   - Press *Enter* (Windows) or *Return* (Mac) to travel down the page.
   - Use the *Space Bar* for fields that need a check mark.

To save the completed form with the data

Once you have filled in the appropriate fields, choose *File* > *Save As* to save a copy of the form with the data.

Type a filename, such as the person's name, and click the *Save* button. You may print this form. The next time you use this file name you will be typing over the saved data. In order to save the old data and the new data you will need to use *Save As* and save the file with the new data under a new name.

To clear all data from a form

Click the *Clear Form Data* button at the top of the form. This will erase all the data from all the fields of the form, creating a blank form.

To print a form

Choose File > Print. If you have difficulty printing the form, or output does not look as expected, check the Print as Image option in the Print dialog box.

To turn pages

Click the Previous Page or Next Page buttons on the toolbar at the top of the screen or press the Right or Left Arrow keys on the keyboard.

To enlarge or reduce the view of the page

Press Ctrl-0 (Windows) or Command-0 (Mac) to fit the page on the screen. Press Ctrl-2 (Windows) or Command-2 (Mac) to fit the width of the page on the screen.

Contents

A. Assessment Information

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A.1

Last four of Social Security Number (SSN)

B. Demographic

Return to Index

B.1 **Legal Name**

First **Middle** **Last and Suffix**

B.2

Date of Birth (MM/DD/YYYY)

B.3 **Gender**

- ☐ Male
- ☐ Female
- ☐ Other - **If "Other", indicate how the individual self- identifies:**

Comments

B.4 **Marital Status:**

- ☐ Now married
- ☐ Separated
- ☐ Widowed/Widower
- ☐ Never Married
- ☐ Divorced

B.5 **Are you a veteran?**

- ☐ Yes
- ☐ No

B.6 **What is your race?**

- ☐ White
- ☐ Native American/Alaskan Native
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian

B.7 **Ethnicity:**

- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Other

B.8 **Safety Risk?**

- ☐ Yes
- ☐ No

↓IF YES, ANSWER RISK CATEGORY BELOW. ↓

B.9 **Safety Risk Categories.**

- ☐ Physical
- ☐ Animal
- ☐ Connectivity Issues
- ☐ Road Conditions
- ☐ Health

B.10

Safety Risk Comments

B.11 **Does the person to be assessed need any additional accommodations?**

☐ No
☐ Yes -**If yes, please describe:**

Comments

B.12 **Type of Telephone Service Used**:

☐ Voice ☐ TTY ☐ Videophone

B.13 **Is an interpreter needed?**

☐ No
☐ Yes -**If yes, please describe:**

Comments

B.14 **Address: Mailing**

Street Address | City | State

Zip | County

B.15 **Phone Numbers**

Home Number

Work Number

Cell Number

B.16 **Email**

Home Email | Work Email

B.17 **Preference to be contacted:**

☐ Email ☐ Mail ☐ Telephone

C. Current Services and Supports

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C.1 **What current services and supports is the individual currently receiving?**

Check all that apply:

- ☐ None
- ☐ Adaptive Equipment
- ☐ Adult Day Services
- ☐ Adult Day Health Services
- ☐ Adult Family Homes
- ☐ Assisted Living
- ☐ Attendant Care
- ☐ Case Management/Care Coordination
- ☐ Children's Health Medical Services (CHMS)
- ☐ Community Transitions
- ☐ Consultation Services
- ☐ Crisis Intervention
- ☐ Developmental Disability Day Treatment Services (DDTCS)
- ☐ Environmental Accessibility Adaptations/Adaptive Equipment
- ☐ Environmental Modifications
- ☐ Foster Care
- ☐ Home Delivered Meals
- ☐ Home Health Aide
- ☐ Mental Health Assessment and/or Treatment
- ☐ Mental Health Targeted Case Management
- ☐ Nurse Visits
- ☐ Occupational Therapy
- ☐ Personal Care Attendant (PCA)
- ☐ Personal Emergency Response System (PERS)
- ☐ Physical Therapy
- ☐ Program for All-Inclusive Care for the Elderly (PACE)
- ☐ Respite
- ☐ Specialized Medical Services
- ☐ Speech Therapy
- ☐ Supplemental Supports
- ☐ Supported Employment
- ☐ Supportive Living
- ☐ Targeted Case Management
- ☐ Substance Abuse Assessment and/or Treatment
- ☐ Other – If "Other", please specify service

Comments

D. Housing

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D.1 **Current Housing Type:**

- ☐ Adult Family Home
- ☐ Licensed Level 1 Assisted Living
- ☐ Licensed Level 2 Assisted Living
- ☐ Certified Level 1 Therapeutic Community (Long Term Residential)
- ☐ Certified Level 2 Therapeutic Community (Long Term Residential)
- ☐ Foster Care
- ☐ Homeless
- ☐ ICF State Operated
- ☐ ICF Private
- ☐ Individual Owned/Controlled Apartment
- ☐ Individual Owned/Controlled Home
- ☐ Individual Owned/Controlled Family Home
- ☐ Institution Hospital
- ☐ Institution, NF | Certified boarding care
- ☐ In someone else's home/apt. -**IF YES, PLEASE SPECIFY RELATIONSHIP TO OWNER/RESIDENT:**

_____

Relationship to Owner

- ☐ Noncertified boarding care
- ☐ Provider-Owned Group Home
- ☐ Provider-Owned Supported Apartment
- ☐ Provider-Owned Supported Housing (Max 4 individuals)
- ☐ Residential Care Facility (RCF)
- ☐ Supported Living Arrangement (with Paid Staff)

E. Emergency Contacts

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E.1

Name

E.2 **Relationship**

- ☐ Spouse/Caregiver/Child
- ☐ Parent
- ☐ Guardian/Legal Representative
- ☐ Friend Neighbor
- ☐ Other

E.3 **Address**

Street Address | City | State

Zip Code

E.4

Directions/Comments

E.5 **Telephone Numbers**

Home Number

Work Number

Cell Number

E.6 **Email**

Home Email | Work Email

F. Activities of Daily Living (ADLs)

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Eating

F.1 **Do you have any difficulties with eating or require support or assistance with eating?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.1 IS YES, COMPLETE THE REMAINDER OF THE EATING SECTION:↓

F.2 **What assistance does the client need to eat by themselves for ages >=18?**

☐ Can eat without help of any kind

☐ Needs and/or gets minimal reminding or supervision

☐ Needs and/or gets help in cutting food, buttering food or arranging food

☐ Needs and/or gets some personal help with feeding or someone needs to be sure that you don't choke

☐ Needs to be fed completely or tube feeding or IV feeding

F.3 **What assistance does the client need to eat by themselves for ages <=17?**

☐ Independent

☐ Intermittent supervision or reminders

☐ Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids

☐ Needs physical assistance. Child can partially feed self (N/A for child 0-24M)

☐ Needs and receives total oral feeding from another. Child is physically unable to participate (N/A for child 0-12M)

☐ Receives tube feeding. Child has documented incidents of choking or reflux on a weekly basis or more that is related to diagnosis or disability.

F.4 **Cuing and Supervision**:

☐ Independent ☐ Intermittently during the task

☐ To initiate the task ☐ Constantly throughout the task

F.5 **Physical Assistance:**

☐ Independent ☐ Limited

☐ Setup/prep ☐ Extensive/total dependence

F.6 **Challenges while eating?**

What inhibits the client from performing the task? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot cut food
- ☐ Chewing problem
- ☐ Choking problem
- ☐ Disease/symptoms interfere with performing task
- ☐ Mouth pain
- ☐ Poor appetite
- ☐ Poor hand to mouth coordination
- ☐ Problems with taste
- ☐ Swallowing problem
- ☐ Other

Other challenges while eating:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.7 **Strengths:**

What does the person do well while eating? (Select all that apply):

- ☐ Cooperates with caregivers
- ☐ Has a good appetite
- ☐ Independent with equipment/adaptations
- ☐ Manages own tube feeding
- ☐ No swallowing problems
- ☐ Person is motivated
- ☐ Takes occasional food by mouth
- ☐ Other

Other strengths while eating:

What additional part of the task can the client do well?

F.8 **Eating Equipment:**

Does the client identify that they need, or they have equipment to assist with eating?

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.8 IS YES, SELECT ALL THAT APPLY FOR F.9 BELOW. ↓

F.9 **Document what equipment client currently uses:**

- ☐ Adaptive Cup
- ☐ Adapted Utensils
- ☐ Dentures
- ☐ Dycem Mat
- ☐ Gastrostomy Tube
- ☐ Hickman Catheter
- ☐ IV
- ☐ Jejunostomy Tube
- ☐ Nasogastric Tube
- ☐ Plate Guard
- ☐ Specialized Medical Equipment
- ☐ Straw
- ☐ Other

F.10 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If "other" was selected describe other equipment utilized.**

Eating Notes/Comments

Bathing

F.11 **Do you have any difficulties with bathing or require support or assistance during bathing?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.11 IS YES, COMPLETE THE REMAINDER OF THE BATHING SECTION:↓

F.12 **What assistance does client need to bath by themselves for ages >= 18?**

☐ Can bathe or shower without any help
☐ Needs and/or gets minimal supervision or reminding
☐ Needs and/or gets supervision only
☐ Needs and/or gets help getting in and out of the tub
☐ Needs and/or gets help washing and drying their body
☐ Cannot bathe or shower, needs complete help

F.13 **What assistance does client need to bath by themselves for ages <= 17?**

☐ Independent
☐ Intermittent supervision or reminders
☐ Needs help in and out of tub
☐ Constant supervision, but child does not need physical assistance
☐ Physical assistance of another, but child is physically able to participate (N/A 0-72M)
☐ Totally dependent on another for all bathing. Child is physically unable to participate. (N/A 0-60M)

F.14 **Cuing and Supervision**:

☐ Independent ☐ Intermittently during the task
☐ To initiate the task ☐ Constantly throughout the task

F.15 **Physical Assistance:**

☐ Independent ☐ Limited
☐ Setup/prep ☐ Extensive/total dependence

F.16 **Challenges while bathing?**

What inhibits the client from performing the task? (Select all that apply):

- ☐ Behavioral issues
- ☐ Afraid of bathing
- ☐ Cannot be left unattended
- ☐ Cannot judge water temperature
- ☐ Disease/symptoms interfere with performing task
- ☐ Unable to shampoo hair
- ☐ Unable to stand alone
- ☐ Other

Other challenges while bathing:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.17 **Strengths:**

What does the person do well while bathing? (Select all that apply):

- ☐ Able to direct caregiver
- ☐ Bathes self with cuing
- ☐ Cooperates with caregivers
- ☐ Enjoys bathing
- ☐ Person is weight bearing
- ☐ Safe when unattended
- ☐ Shampoos hair
- ☐ Other

Other strengths while bathing:

What additional part of the task can the client do well?

F.18 **Bathing Equipment:**

Does the client identify that they need, or they have equipment to assist with Bathing?

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.18 IS YES, SELECT ALL THAT APPLY FOR F.19 BELOW. ↓

F.19 **Document what equipment client currently uses**:

- ☐ Bath Bench
- ☐ Grab Bars
- ☐ Hand-Held Shower
- ☐ Hoyer Lift
- ☐ Roll-in Shower Chair
- ☐ Shower Chair
- ☐ Specialized Medical Equipment
- ☐ Transfer Bench
- ☐ Other

F.20 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If "other" was selected describe other equipment utilized**.

Bathing Notes/Comments*:*

Dressing

F.21 **Do you have any difficulties with dressing or require support or assistance during dressing?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.21 IS YES, COMPLETE THE REMAINDER OF THE DRESSING SECTION↓

F.22 **What assistance does the client need to dress by themselves for ages >=18?**

- ☐ Can dress without any help
- ☐ Needs and/or gets minimal supervision
- ☐ Needs and/or gets some help from another person to put clothes on
- ☐ Cannot dress themselves, somebody else dresses them
- ☐ Is never dressed

F.23 **What assistance does the client need to dress by themselves for ages <=17?**

- ☐ Independent
- ☐ Intermittent supervision or reminders, may need physical assistance with fasteners, shoes or layout out clothes
- ☐ Constant supervision, but no physical assistance (N/A for child 0-48M)
- ☐ Physical assistance or presence of another at all times, but child is able to physically participate (N/A for child 0-36M)
- ☐ Totally dependent on another for all dressing. Child is unable to physically participate (N/A if child 0-12M)

F.24 **Cuing and Supervision**:

- ☐ Independent
- ☐ To initiate the task
- ☐ Intermittently during the task
- ☐ Constantly throughout the task

F.25 **Physical Assistance:**

- ☐ Independent
- ☐ Setup/prep
- ☐ Limited
- ☐ Extensive/total dependence

F.26 **Challenges while dressing?**

What inhibits the client from performing the task? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot button clothing
- ☐ Cannot dress lower extremities
- ☐ Cannot lift arms
- ☐ Cannot put on shoes/socks
- ☐ Disease/symptoms interfere with performing task
- ☐ Unable to lie
- ☐ Unable to undress independently
- ☐ Unable to zip
- ☐ Will wear dirty clothes
- ☐ Other

Other challenges while dressing:

Provide supporting documentation** (e.g.,per client,due to needs, what by who,how often)**:

F.27 **Strengths:**

What does the person do well while dressing? (Select all that apply)**:**

- ☐ Able to direct caregiver
- ☐ Buttons clothing
- ☐ Cooperates with caregivers
- ☐ Gets dressed with cuing
- ☐ Person is motivated
- ☐ Puts on shoes and socks
- ☐ Uses assistive devices
- ☐ Other

Other strengths while dressing:

What additional part of the task can the client do well?

F.28 **Dressing Equipment: Does the client identify that they need or they have equipment to assist with dressing?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.28 IS YES, SELECT ALL THAT APPLY FOR F.29 BELOW↓

F.29 **Document what equipment client currently uses**:

- ☐ Adaptive Clothing
- ☐ Button Hook
- ☐ Elastic Shoe Laces
- ☐ Helmet
- ☐ Orthotics
- ☐ Prosthesis
- ☐ Protective Gear
- ☐ Reacher
- ☐ Sock Aid
- ☐ Specialized Medical Equipment
- ☐ TED Hose
- ☐ Other

F.30 **Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If "other" was selected describe other equipment utilized.**

Dressing Notes/Comments

Personal Hygiene/Grooming

F.31 **Does the person have any difficulties with or require support or assistance to take care of their grooming and hygiene needs?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.31 IS YES, COMPLETE THE REMAINDER OF THE PERSONAL HYGIENE/GROOMING SECTION↓

F.32 **What assistance does client need to groom by themselves for ages >= 18?**

- ☐ Can comb hair, wash face, shave or brush teeth without any help of any kind
- ☐ Needs and/or gets supervision or reminding about grooming activities
- ☐ Needs and/or gets daily help from another person
- ☐ Is completely groomed by somebody else

F.33 **What assistance does client need to groom by themselves for ages <= 17?**

☐ Independent
☐ Intermittent supervision or reminders
☐ Help of another to complete the task, but child is able to physically participate (N/A if child 0-48M)
☐ Totally dependent on another for all dressing. Child is unable to physically participate (N/A if child 0-12M)
☐ Child is unable to physically participate (N/A if child 0-24M)

F.34 **Cuing and Supervision**:

☐ Independent ☐ Intermittently during the task
☐ To initiate the task ☐ Constantly throughout the task

F.35 **Physical Assistance:**

☐ Independent ☐ Limited
☐ Setup/prep ☐ Extensive/total dependence

F.36 **Challenges while grooming/hygiene?**

What inhibits the client from performing the task? (Select all that apply):

☐ Behavioral issues ☐ Disease/symptoms interfere with performing task
☐ Cannot brush/comb hair ☐ Unaware of grooming needs
☐ Cannot brush teeth ☐ Other
☐ Cannot raise arms

Other challenges while grooming/hygiene:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.37 **Strengths:**

What does the person do well in taking care of their own grooming/hygiene needs? (Select all that apply):

☐ Able to apply makeup, lotions, etc. ☐ Brushes teeth/dentures
☐ Able to brush/comb hair ☐ Can shave themselves
☐ Able to trim nails ☐ Cooperates with caregiver
☐ Able to wash hands/face ☐ Person is motivated
☐ Other

Other strengths while grooming:

What additional part of the task can the client do well?

F.38 **Personal Hygiene/Grooming Equipment: Does the client identify that they need or they have equipment to assist with grooming?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.38 IS YES, SELECT ALL THAT APPLY FOR F.39 BELOW:↓

F.39 **Document what equipment client currently uses:**

- ☐ Adapted Toothbrush
- ☐ Dental Floss Holder | Flossing Aid
- ☐ Dentures
- ☐ Electric Razor
- ☐ Special Type of Toothbrush
- ☐ Splint
- ☐ Other

F.40 **Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If "other" was selected describe other equipment utilized.**

Personal Hygiene/Grooming Notes/Comments:

Toilet Use/Continence

F.41 **Does the person have any difficulty with toileting or need assistance or support with toileting?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.41 IS YES, COMPLETE THE REMAINDER OF THE TOILET USE/CONTINENCE SUPPORT SECTION:↓

F.42 **What assistant does the client need to manage using the toilet by themselves for ages >=18?**

- ☐ Can use the toilet without help, including adjusting clothing
- ☐ Needs and/or gets some help to get to and on the toilet, but doesn't have accidents
- ☐ Has accidents sometimes but not more than once a week
- ☐ Only has accidents at night
- ☐ Has accidents more than once a week
- ☐ Wets their pants and has bowel movement in their clothes very often
- ☐ Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters)

F.43 **What assistant does the client need to manage using the toilet by themselves for ages <=17?**

- ☐ Independent
- ☐ Intermittent supervision, cuing or minor physical assistance such as clothes adjustments or hygiene. No Incontinence (N/A for child 0-60M)
- ☐ Usually continent of bowel and bladder, but has occasional accidents requiring physical assistance (N/A for child 0-60M)
- ☐ Usually continent of bowel and bladder, but needs physical assistance or constant supervision for all parts of the task (N/A for child 0-60M)
- ☐ Incontinent of bowel or bladder. Diapered. (N/A for child 0-48M)
- ☐ Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters)

F.44 **Cuing and Supervision**:

- ☐ Independent
- ☐ To initiate the task
- ☐ Intermittently during the task
- ☐ Constantly throughout the task

F.45 **Physical Assistance:**

- ☐ Independent
- ☐ Setup/prep
- ☐ Limited
- ☐ Extensive/total dependence

F.46 **Challenges with toileting?**

What inhibits the client from performing the task? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot always find bathroom
- ☐ Cannot change incontinence pads. Cannot do own peri care.
- ☐ Cannot empty ostomy/catheter bag
- ☐ Experiences urgency
- ☐ Painful urination
- ☐ Refuses to use pads/briefs
- ☐ Requires peri-care after toilet use
- ☐ Unaware of need
- ☐ Wets/soils bed/furniture
- ☐ Other

Other challenges while toileting:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.47 **Strengths:**

What does the person do well with toileting and staying dry and clean? (Select all that apply):

- ☐ Able to uses incontinence products
- ☐ Assists caregiver with transfer
- ☐ Aware of need to use toilet
- ☐ Can toilet with cuing
- ☐ Cooperates with caregivers
- ☐ Does not need assistance at night
- ☐ Empties own ostomy/catheter bag
- ☐ Other

Other strengths while toileting:

What additional part of the task can the client do well?

F.48 **Toilet Use/Continence Support Equipment: Does the client identify that they need or they have equipment to assist with toileting?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.48 IS YES, SELECT ALL THAT APPLY FOR F.49 BELOW:↓

F.49 **Document what equipment client currently uses:**

- ☐ Barrier Cream
- ☐ Bed Pan
- ☐ Incontinence Briefs
- ☐ Pads
- ☐ Colostomy Bag
- ☐ Commode
- ☐ Disinfectant Spray
- ☐ External Catheter
- ☐ Gloves
- ☐ Grab Bars
- ☐ Ileostomy Bag
- ☐ Internal Catheter
- ☐ Mattress Cover
- ☐ Raised Toilet Seat
- ☐ Specialized Medical Equipment
- ☐ Urinal
- ☐ Other

F.50 **Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If "other" was selected describe other equipment utilized.**

Toilet Use/Continence Support Notes/Comments

Mobility – Walking and Wheeling

F.51 **Does the person have any difficulty with mobility or require support or assistance to get around?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.51 IS YES, COMPLETE THE REMAINDER OF THE MOBILITY-WALKING AND WHEELING SECTION:↓

F.52 **What assistance does the client need to walk by themselves for ages >=18?**

☐ Walks without help of any kind
☐ Can walk with help of a cane, walker crutch or push wheelchair
☐ Needs and/or gets help from one person to help walk
☐ Needs and/or gets help from two people to help walk
☐ Cannot walk at all

F.53 **What assistance does client need to walk by themselves for ages <=17?**

☐ Independent. Ambulatory without device.
☐ Can mobilize with the assist of a device but does not need personal assistance.
☐ Intermittent physical assistance of another (n/a 0-24 M). (this does not include supervision for safety of a child underage)
☐ Needs constant physical assistance of another. Includes child who remains bedfast (n/a 0-12M)

F.54 **Cuing and Supervision**:

☐ Independent ☐ Intermittently during the task
☐ To initiate the task ☐ Constantly throughout the task

F.55 **Physical Assistance:**

☐ Independent ☐ Limited
☐ Setup/prep ☐ Extensive/total dependence

F.56 **Challenges getting around their home.**

What inhibits the client from performing the task? (Select all that apply):

☐ Behavioral issues
☐ Activity limited; afraid of falling
☐ Cannot propel wheelchair
☐ Disease/symptoms interfere with performing task
☐ Leans to one side
☐ Misplaces/forgets assistive device
☐ Poor navigation
☐ Unable to exit in emergency
☐ Unable to walk/bear weight
☐ Will not use assistance devices
☐ Other

Other challenges getting around home:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.57 **Challenges getting around community.**

What inhibits the client from performing the task? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot open doors
- ☐ Disease/symptoms interfere with performing task
- ☐ Needs assistance with stairs
- ☐ activity limited afraid of falling
- ☐ Difficulty navigating unfamiliar environments
- ☐ Gets lost outside residence
- ☐ Needs assistance to evacuate
- ☐ Needs wheelchair for distance
- ☐ Poor safety awareness
- ☐ Other

Other challenges around community:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.58 **Strengths:**

What does the person do well when getting around their home? (Select all that apply):

- ☐ Able to exit in emergency
- ☐ Aware of own safety
- ☐ Cooperates with caregivers
- ☐ Has a steady gait
- ☐ Motivated
- ☐ Propels own wheelchair
- ☐ Sees well enough to navigate independently
- ☐ Other

Other strengths in mobility at home:

What additional part of the task can the client do well?

F.59 **Strengths**

What does the person do well when getting around their community? (Select all that apply)**:**

- ☐ Can evacuate in emergency
- ☐ Has good endurance
- ☐ Independent with stairs
- ☐ Navigates safely in community
- ☐ Residence has ramp
- ☐ Will ask for assistance
- ☐ Other

Other strengths in mobility in community:

What additional part of the task can the client do well?

F.60 **Mobility:**

Walking and Wheeling Equipment: Does the person have or need any adaptive equipment to assist with mobility?

☐ Yes ☐ No ☐ Chose not to answer

IF F.60 IS YES, SELECT ALL THAT APPLY FOR F.61 BELOW:

F.61 **Document what equipment client currently uses:**

- ☐ Air Pad
- ☐ Cane
- ☐ Crutch
- ☐ Gait Belt
- ☐ Gel Pad
- ☐ Manual Wheelchair
- ☐ Motorized Wheelchair
- ☐ Medical Response Alert
- ☐ Medical Response Alert Unit
- ☐ Prostheses
- ☐ Quad Cane
- ☐ Ramps
- ☐ Repositioning Wheelchair
- ☐ Room Monitor
- ☐ Scooter
- ☐ Service Animal
- ☐ Specialized Medical Equipment
- ☐ Splint | Braces
- ☐ Walker
- ☐ Walker with Seat
- ☐ Other

F.62 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If "other" was selected describe other equipment utilized.**

Mobility – Walking and Wheeling Comments/Notes

Positioning

F.63 **Does the person have any difficulties with positioning or require support or assistance when positioning?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.63 IS YES, COMPLETE THE REMAINDER OF THE POSITIONING SECTION: ↓

F.64 **What assistance does client need to manage sitting up or moving around by themselves for ages >= 18?**

- ☐ Can move in bed without any help
- ☐ Needs and/or gets help sometimes to sit up
- ☐ Always needs and/or gets help to sit up at least daily
- ☐ Always needs and/or gets help to be turned or change positions

F.65 **What assistance does client need to manage turning and positioning by themselves for ages <=17?**

- ☐ Independent. Ambulatory without Device
- ☐ Needs occasional assistance of another person or device to change position less than daily.
- ☐ Needs intermittent assistance of another on a daily basis to change positions. Child is physically able to participate
- ☐ Needs total assistance in turning and positioning. Child is unable to participate

F.66 **Cuing and Supervision**:

- ☐ Independent
- ☐ Intermittently during the task
- ☐ To initiate the task
- ☐ Constantly throughout the task

F.67 **Physical Assistance:**

☐ Independent ☐ Limited
☐ Setup/prep ☐ Extensive/total dependence

F.68 **Challenges while positioning?**

What inhibits the client from performing the task? (Select all that apply):

☐ Behavioral issues
☐ Bedridden all | most of the time
☐ Cannot elevate legs | feet
☐ Disease | Symptoms interfere with performing task
☐ Chair fast all | most of the time
☐ Falls out of bed
☐ Slides down in chair
☐ Slips down in bed
☐ Unable to use trapeze
☐ Unaware of need to reposition
☐ Other

Other challenges while positioning:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.69 **Strengths:**

What does the person do well when repositioning? (Select all that apply):

☐ Able to elevate legs
☐ Asks for assistance
☐ Aware of need to reposition
☐ Cooperates with Caregiver
☐ Directs caregiver to assist with tasks
☐ Motivated
☐ Uses Trapeze
☐ Other

Other strengths while positioning: (*If other is selected provide supporting documentation)*

What additional part of the task can the client do well?

F.70 **Positioning Equipment: Does the client identify that they need, or they have equipment to assist with positioning?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.70 IS YES, SELECT ALL THAT APPLY FOR F.71 BELOW: ↓

F.71 **Document what equipment client currently uses:**

☐ Alternating pressure mattress
☐ Bubble mattress
☐ Brace
☐ Electronic bed
☐ Flotation mattress
☐ Manual bed
☐ Posey or other enclosed bed
☐ Side rails
☐ Specialized Medical Equipment
☐ Water mattress
☐ Other

F.72 **Document if client reports they need adaptive equipment but currently do not have, or has but does not use – If "other" was selected describe other equipment utilized.**

Positioning Comments/Notes

Transfer

F.73 **Does the person have any difficulties with transfers or require support or assistance when making transfers?**

☐ Yes ☐ No ☐ Chose not to answer

↓ IF F.73 IS YES, COMPLETE THE REMAINDER OF THE TRANSFERS SECTION: ↓

F.74 **What assistance does the client need to transfer in/out of bed and in/out of chair, by themselves for ages >=18)?**

☐ Can get in and out of a bed or chair without help of any kind
☐ Needs somebody to be there to guide them but they can move in and out of a bed or chair
☐ Needs and/or gets one other person to help
☐ Needs and/or gets two other people or a mechanical aid to help

F.75 **What assistance does client need to manage transfers, by themselves for ages <=17)?**

☐ Independent
☐ Needs intermittent supervision or reminders (i.e. cuing or guidance only).
☐ Needs physical assistance, but child is able to participate. Excludes car seat, highchair, crib for toddler age child. (N/A for child 0-30 months)
☐ Needs total assistance of another and child is physically unable to participate. (N/A for child 0-18 months)
☐ Must be transferred using a mechanical device (i.e. Hoyer lift)

F.76 **Cuing and Supervision**:

☐ Independent ☐ Intermittently during the task
☐ To initiate the task ☐ Constantly throughout the task

F.77 **Physical Assistance:**

☐ Independent ☐ Limited
☐ Setup/prep ☐ Extensive/total dependence

F.78 **Challenges with making transfers.**

What inhibits the client from performing the task? (Select all that apply)

☐ Behavioral issues
☐ Afraid of falling
☐ Afraid of Hoyer lift
☐ Disease | Symptoms interfere with performing task
☐ Two -Person transfer
☐ Unable to transfer without assistance
☐ Unsteady during transfer
☐ Other

Other challenges with making transfers:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

F.79 **Strengths:**

What does the person do well when transferring? (Select all that apply):

- ☐ Ask for assistance
- ☐ Aware of safety
- ☐ Can transfer self-using a lift
- ☐ Cooperates with Caregiver
- ☐ Has good upper body strength
- ☐ Motivated
- ☐ Transfers with some support
- ☐ Other

Other strengths while transferring:

What additional part of the task can the client do well?

F.80 **Transfers Equipment:**

Does the client identify that they need, or they have equipment to assist with transferring?

☐ Yes ☐ No ☐ Chose not to answer

↓IF F.80 IS YES, SELECT ALL THAT APPLY FOR F.81 BELOW:↓

F.81 **Document what equipment client currently uses**:

- ☐ Bed rail
- ☐ Brace
- ☐ Ceiling lift tracking system
- ☐ Electronic bed
- ☐ Gait Belt
- ☐ Hoyer or similar device
- ☐ Lift Chair
- ☐ Slide Board
- ☐ Specialized Medical Equipment
- ☐ Other

F.82 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If "other" was selected describe other equipment utilized**.

Transfers Comments/Notes

G. Instrumental Activities of Daily Living (IADLs)

Return to Index

Medication Management (Age>=18)

G.1 **Do you take any medication(s)?**

(This question is asking if the client is taking any medications, not if the client has any difficulties with medications.)

☐ Yes ☐ No ☐ Chose not to answer

↓ IF G.1 IS YES, COMPLETE THE REMAINDER OF THE MEDICATIONS SECTION: ↓

G.2 **Does the person need assistance with medication management?**

☐ Needs no help or supervision
☐ Needs medication setup
☐ Needs visual or verbal reminders
☐ Needs medication administration

G.3 **Challenges:**

What difficulties does the person have with medication management?

☐ Behavioral issues
☐ Cannot crush pills
☐ Cannot open containers
☐ Cannot fill syringe
☐ Disease | Symptoms interfere with performing task
☐ Doesn't take medications due to cost
☐ Does not use correct dosage
☐ Forgets to take medication
☐ Has multiple prescriptions
☐ Takes outdated or expired medications
☐ Unable to read labels
☐ Unaware of dosages
☐ Use multiple pharmacies
☐ Other

Other challenges with medication:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

G.4 **Strengths**

What does the person do well when managing medications? (Select all that apply):

☐ Able to manage multiple medications
☐ Able to open containers
☐ Able to put medications in mouth
☐ Able to use | give own injections
☐ Aware of frequency & dosages
☐ Aware of potential side effects
☐ Can crush pills
☐ Can fill | use syringe
☐ Takes medications as prescribed
☐ Understands purpose of medications
☐ Other

Other strengths in medication:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

G.5 **Medication Management Equipment:**

Does the person have or need any adaptive equipment to assist with medication management?

☐ Yes ☐ No ☐ Chose not to answer

↓IF G.5 IS YES, SELECT ALL THAT APPLY FOR G.6 BELOW:↓

G.6 **Medication Equipment Status?** (select all that apply):

- ☐ CompuMed
- ☐ Medi-Minder
- ☐ Medi-Set
- ☐ Pill Crusher
- ☐ Pill Cutter
- ☐ Specialized Medical Equipment
- ☐ Syringe
- ☐ Other

G.7 **Document if client reports they need adaptive equipment but currently do not have or has but does not use – If "other" was selected describe other equipment utilized**.

Medication Management Comments/Notes

Meal Preparation (>=18)

G.8 **Does the person have any difficulty preparing meals?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF G8 IS YES, COMPLETE THE REMAINDER OF THE MEAL PREPARATION SECTION: ↓

G.9 **Does the person need assistance with meal preparation?**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.10 **Challenges:**

What difficulties does the person have with preparing meals? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot cut/peel/chop
- ☐ Does not know how to cook
- ☐ cannot plan meals
- ☐ Cannot reach stove
- ☐ Diseases/symptoms interfere with performing task
- ☐ Keeps spoiled food
- ☐ Leaves burners on
- ☐ Special diet
- ☐ Other

Other challenges with preparing meal:

Provide supporting documentation** (e.g., per client, due to, needs, what, by who, how often)**:

G.11 **Strengths:**

What does the person do well when preparing simple meals? (Select all that apply):

- ☐ Able to follow special dietary needs
- ☐ Assists with meals
- ☐ Aware of food allergies
- ☐ Can prepare a simple meal
- ☐ Can prepare food with cueing
- ☐ Can use the microwave
- ☐ Directs caregiver to prepare meal
- ☐ Has accessible kitchen
- ☐ Makes good meal choices
- ☐ Plans own menus
- ☐ Other

Other strengths in meal preparation:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

Transportation (Age >= 16)

G.12 **Does the person have difficulty with transportation?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF G.12 TO YES, COMPLETE THE REMAINDER OF THE TRANSPORTATION SECTION: ↓

G.13 **Does the person need assistance with transportation?**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.14 **Challenges**

What difficulties does the person have with transportation? (Select all that apply):

- ☐ Behavioral issues
- ☐ Difficult to transfer
- ☐ Difficulty communicating with drivers
- ☐ Disease/symptoms interfere with performing task
- ☐ Needs escort if public transportation is used
- ☐ Needs to take walker/ wheelchair
- ☐ Needs to use vehicle with lift
- ☐ No car
- ☐ Unable to arrange own transportation
- ☐ Will not ride a bus
- ☐ Other

Other challenges with transportation:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

G.15 **Strengths:**

What does the person do well related to transportation? (Select all that apply):

- ☐ Can find and read schedules, phone #s
- ☐ Can ride bus without assistance
- ☐ Communicates needed information with driver
- ☐ Has a vehicle with a lift
- ☐ Has own car
- ☐ Has handicap parking sticker/license
- ☐ Knows bus routes
- ☐ Other

Other strengths with transportation:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

Housework (Age >=18)

G.16 **Does the person need assistance with housework?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF G.16 YES, COMPLETE THE REMAINDER OF THE HOUSEWORK SECTION: ↓

G.17 **Amount of assistance with "light" housekeeping:**

☐ Needs no help or supervision
☐ Sometimes needs assistance or occasional supervision
☐ Often needs assistance or constant supervision
☐ Always or nearly always needs assistance

G.18 **Amount of assistance with "heavy" housekeeping:**

☐ Needs no help or supervision
☐ Sometimes needs assistance or occasional supervision
☐ Often needs assistance or constant supervision
☐ Always or nearly always needs assistance

G.19 **Amount of assistance with doing their own laundry:**

☐ Needs no help or supervision
☐ Sometimes needs assistance or occasional supervision
☐ Often needs assistance or constant supervision
☐ Always or nearly always needs assistance

G.20 **Challenges:**

What difficulties does the person have with housework? (Select all that apply):

☐ Behavioral issues
☐ Allergies to dust, pollen, etc.
☐ Cannot make or change bedding
☐ Cannot operate washer/dryer
☐ Cannot see when surfaces need cleaning
☐ Does not have lawnmower
☐ Does not have vacuum cleaner
☐ Disease/symptoms interfere with performing task
☐ Has chemical sensitivities
☐ Unaware of need
☐ Other

Other challenges with housework:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

G.21 **Strengths:**

What does the person do well related to housework? (Select all that apply):

☐ Able to make bed
☐ Able to sweep
☐ Can do dishes
☐ Can do light housekeeping
☐ Can do light personal laundry
☐ Can fold clothes
☐ Can instruct caregiver
☐ Can take out garbage
☐ Can wash windows
☐ Does housework with cueing
☐ Other

Other strengths doing housework:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

Telephone Use (Age >=16)

G.22 **Does the person need assistance to use the telephone?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF G.22 IS YES, COMPLETE THE REMAINDER OF THE TELEPHONE USE SECTION:↓

G.23 **Amount of assistance using the telephone:**

☐ Needs no help or supervision
☐ Sometimes needs assistance or occasional supervision
☐ Often needs assistance or constant supervision
☐ Always or nearly always needs assistance

G.24 **Challenges- What difficulty does the person have with using the telephone? (Select all that apply):**

☐ Behavioral issues
☐ Cannot dial phone
☐ Cannot get to phone
☐ Cannot hear phone ringing
☐ Difficulty hearing | understanding callers
☐ Disease | Symptoms interfere with performing task
☐ No telephone
☐ Other

Other challenges using telephone:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

G.25 **Strengths:**

What does the person do well when using the telephone? (Select all that apply):

☐ Can dial phone
☐ Can take messages
☐ Can use PERS
☐ Can use phone book | 411 service
☐ Can use relay service
☐ Can use speaker phone
☐ Other

Other strengths using telephone:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

Shopping (Age >=16)

G.26 **Does the person need assistance with shopping?**

☐ Yes ☐ No ☐ Chose not to answer

↓ If G.26 YES, complete the remainder of the Shopping section:↓

G.27 **Amount of assistance with shopping for food or other items**:

☐ Needs no help or supervision
☐ Sometimes needs assistance or occasional supervision
☐ Often needs assistance or constant supervision
☐ Always or nearly always needs assistance

G.28 **Challenges – What difficulties does the person have with shopping? (Select all that apply):**

- ☐ Behavioral issues
- ☐ Cannot carry heavy items
- ☐ Cannot reach items
- ☐ Cannot read labels
- ☐ Cannot see/locate items
- ☐ Cannot shop online
- ☐ Disease/symptoms interfere with performing task
- ☐ Other

Other challenges with shopping:

Provide supporting documentation *(e.g., per client, due to, needs, what, by who, how often):*

G.29 **Strengths – What is the person able to do when shopping? (Select all that apply):**

- ☐ Able to arrange transportation
- ☐ Able to budget income and expenses
- ☐ Able to communicate with store personnel
- ☐ Able to make shopping lists
- ☐ Can carry small items
- ☐ Can navigate within the store
- ☐ Can see/identify needed items
- ☐ Other

Other strengths while shopping:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

Finances (Age>=16)

G.30 **Does the person need assistance with finances and/or healthcare or financial paperwork?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF G.30 IS YES, COMPLETE THE REMAINDER OF THE FINANCES SECTION:↓

G.31 **Amount of assistance with finances:**

- ☐ Needs no help or supervision
- ☐ Sometimes needs assistance or occasional supervision
- ☐ Often needs assistance or constant supervision
- ☐ Always or nearly always needs assistance

G.32 **Challenges:**

What difficulty does the person have with finances? (Select all that apply):

- ☐ Behavioral issues
- ☐ Cannot budget
- ☐ Cannot see/read bills or account information
- ☐ Difficulty keeping up with paperwork to maintain eligibility for health care and other benefits
- ☐ Difficulty differentiating between needs /wants
- ☐ Has no POA/needs
- ☐ Hides money
- ☐ Disease/symptoms interfere with performing task
- ☐ Vulnerable to financial exploitation
- ☐ Will not pay bills
- ☐ Other:

Other challenges with finances:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

G.33 **Strengths – What does the person do well related to finances? (Select all that apply):**

- ☐ Can budget income and expenses
- ☐ Can use EBT card
- ☐ Can write checks and pay bills
- ☐ Has a payee
- ☐ Has auto payment plan
- ☐ Has direct deposit
- ☐ Has guardian/Power of Attorney (POA)
- ☐ Other

Other strengths with finances:

Provide supporting documentation (e.g., per client, due to, needs, what, by who, how often):

H. Health

Return to Index

Eating Habits and Nutrition

H.1 **Does the person have any concerns about their eating habits?**

Note: This relates to nutritional concerns.

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

↓IF H.1IS YES, CHECK ALL THAT APPLY IN H.2 BELOW: ↓

H.2 **Check all that apply:**

☐Anorexia
☐Bulimia
☐Complains about taste of food
☐Obesity
☐Overeating
☐Polydipsia
☐Recent weight gain
☐Recent weight loss
☐ Other- Please provide supporting documentation for "other

H.3 **Please provide supporting documentation for other eating habits.**

Endocrine

H.4 **Does the person have a thyroid problem?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

↓IF H.4 IS YES, CHECK ALL THAT APPLY IN H.5 BELOW: ↓

H.5 **Check all that apply:**

☐Hyperthyroid
☐Hypothyroid
☐Other

H.6 **Other Endocrine:**

Thyroid problem. Please provide supporting documentation for other endocrine-thyroid problems.

H.7 **Does the person have diabetes?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

↓IF H.7 IS YES, CHECK ALL THAT APPLY IN H.8 BELOW:↓

H.8 **Check all that apply:**

☐ Diet and exercise (controlled)
☐ Non-insulin dependent diabetes
☐ Type 1-insulin dependent
☐ Type 2 - insulin dependent
☐ Other.

H.9 **Other Endocrine**-Diabetes problem. Please provide supporting documentation for other endocrine-diabetes problems.

Gastrointestinal

H.10 **Does the person have any stomach problems or problems with constipation, diarrhea, gastrointestinal disorders, or elimination (e.g. ostomy care, bowel program)?**

☐ Yes ☐ No ☐ Chose not to answer

↓IF H.10 YES, CHECK ALL THAT APPLY IN H.11 BELOW: ↓

H.11 **Check all that apply:**

☐ Blood in stool
☐ Constipation
☐ Crohn's Disease
☐ Diarrhea
☐ Gastrointestinal Ulcers
☐ Gastrointestinal Reflux Disease (GERD)
☐ Heartburn
☐ Hepatitis C
☐ Irritable bowel syndrome
☐ Ulcerative Colitis
☐ Frequent nausea
☐ Vomiting
☐ Other

H.12 **Other stomach problems. Please provide supporting documentation for other stomach problems.**

Genitourinary

H.13 **Does the person have problems with urination or elimination** (e.g. catheters, bladder program, etc.)**?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

↓IF H.13 YES, CHECK ALL THAT APPLY ON H.14 BELOW: ↓

H.14 **Check all that apply:**

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Pain on urination
- ☐ Renal failure
- ☐ Urinary Tract Infection (UTI)
- ☐ Other

H.15 **Other urination problem. Please provide supporting documentation for other urination problems.**

Heart/Circulation

H.16 **Does the person have any heart or circulation problems?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

↓IF H.16 IS YES, CHECK ALL THAT APPLY IN H.17 BELOW: ↓

H.17 **Check all that apply:**

- ☐ Anemia
- ☐ Angina | Chest Pain
- ☐ Atherosclerotic heart disease
- ☐ Cardiac arrest (heart attack)
- ☐ Cardiac Arrhythmias
- ☐ Clotting issues
- ☐ Congestive heart failure (CHF)
- ☐ Deep vein thrombosis
- ☐ Hypertension
- ☐ Hypotension
- ☐ Heart palpitations
- ☐ Peripheral vascular disease
- ☐ Reynaud's Syndrome
- ☐ Shortness of breath
- ☐ Other

H.18 **Other heart or circulation problems. Please provide supporting documentation for other heart or circulation problems.**

Mental Health

H.19 **Does the person have a mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition excluding a primary diagnosis of dementia, Alzheimer's disease, or other related cognitive conditions?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

H.20 **Check all that apply:**

- ☐ Anxiety
- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Dysthymia
- ☐ Eating Disorders
- ☐ Major Depression
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Panic Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Seasonal Affective Disorder
- ☐ Other

Please provide supporting documentation.

Comments

H.21 **Has the mental disorder resulted in significantly impaired functioning in major life activities that would be appropriate for the person's developmental stage within the past 3 to 6 months? (Age>=18)**

☐ Yes ☐ No

Musculoskeletal

H.22 **Does the person have any muscle, bone or joint conditions (including loss of limb)?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

H.23 **Check all that apply:**

- ☐ Amputation
- ☐ Arthritis/Osteoarthritis
- ☐ Arthritis/Rheumatoid
- ☐ Bursitis
- ☐ Contractures
- ☐ Degenerative disease
- ☐ Fractures
- ☐ Gout
- ☐ Hip fracture
- ☐ Hip/Knee replacement
- ☐ Missing limb
- ☐ Osteoporosis
- ☐ Post-polio syndrome
- ☐ Scleroderma
- ☐ Other

H.24 **Other Musculoskeletal issues. Please provide supporting documentation for other musculoskeletal issues.**

Comments

Neurodevelopmental Disorder

H.25 **Does the person have any neurodevelopmental disorders or conditions?**

☐ Yes ☐ No ☐ Chose not to answer

H.26 **Check all that apply:**

- ☐ Autism Spectrum Disorder (ASD)
- ☐ Brain Injury onset prior to age 22
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Epilepsy/Seizure Disorder
- ☐ Intellectual or Developmental Disability
- ☐ Spina Bifida
- ☐ Other related condition

H.27 **Other Neurodevelopmental Disorder.**

Please provide supporting documentation for other neurodevelopmental disorder.

Comments

Neurological/Central Nervous System

H.28 **Does the person have any neurological conditions?**

☐ Yes ☐ No ☐ Chose not to answer

H.29 **Check all that apply:**

- ☐ Alzheimer's
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Brain Injury/Head Injury
- ☐ Dementia
- ☐ Epilepsy
- ☐ Friederich's Ataxia
- ☐ History of concussions
- ☐ Huntington's Chorea
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy Paraplegia
- ☐ Parkinson's Disease
- ☐ Quadriplegia
- ☐ Stroke-Cerebrovascular Accident (CVA)
- ☐ Swallowing Disorders
- ☐ Transient Ischemic Attack (TIA)
- ☐ Other

H.30 **Other neurological conditions. Please provide supporting documentation for other neurological conditions.**

Comments

Reproductive Female (Age 14-55)

H.31 **Are you pregnant? (**This question is only for females that are between the ages of 14-55.)

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

Respiratory

H.32 **Does the person have any breathing problems?**

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

H.33 **Check all that apply Breathing.**

☐ Asthma
☐ Bronchitis
☐ Chronic emphysema
☐ Other
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Pneumonia
☐ Productive cough

Skin

H.34 **Does the person have any skin conditions or problems with the skin?**

☐ Yes ☐ No ☐ Chose not to answer

H.35 **Check all that apply:**

☐ Bruises
☐ Burns - 2 degree or greater
☐ Decubitus ulcer
☐ Eczema
☐ Open lesions, abrasions, cuts or skin tears
☐ Psoriasis
☐ Stasis ulcers
☐ Surgical site
☐ Other

H.36 **Does the client report the condition is healing or non-healing?**

☐ Healing
☐ Non-healing

H.37 **Other skin problem. Please provide supporting documentation for other skin problems:**

Comments

Treatment/Monitoring

LEGEND TABLE

Treatment/Monitoring	Performed By:	Frequency
The treatment and monitoring section contain several tables all structured the same. The first column lists the type of treatment being monitored. Each cell has a checkbox to select the treatment.	The second column in each table contains a drop-down list to indicate who performs or monitors the corresponding treatment. The choices include: • Caregiver/Parent • Nurse/OT/PT/Physician • Direct Care Worker/ST/Certified Nurse Aide • Self	The third column in each table contains a drop-down list that indicates the frequency that the corresponding treatment or monitoring occurs. The choices include: • Daily > 21 Day Duration for DAAS Only • Daily <= 21 Day Duration • >= 30 Days for DDS Only • Weekly but not daily • Monthly but not daily

H.38 CARDIAC TABLE

Treatment/Monitoring	Performed By	Frequency
☐ Cardioverter-Defibrillator -wearable	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Cardioverter-Defibrillator -implanted	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Pacemaker	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Vital Signs	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Blood Pressure	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.39 **ELIMINATION**

Treatment/Monitoring	Performed By	Frequency
☐ Bladder Irrigation	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Bowel Program	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Enemas	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.40 CATHETER INSERTION AND | OR MAINTENANCE

Treatment/Monitoring	Performed By	Frequency
☐ Sterile catheter changes	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Clean self-catheterization	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Intermittent catheter	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.41 OSTOMY CARE

Treatment/Monitoring	Performed By	Frequency
☐ Colostomy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Ileostomy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Scheduled Toileting program	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.42 FEEDING AND NUTRITION FEEDING TUBE

Treatment/Monitoring	Performed By	Frequency
☐ Gastrojejunostomy (GJ tube)	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Gastrostomy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Jejunostomy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Nasogastric	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Levin tubes	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Intravenous feedings	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Other Treatments

Please provide supporting documentation.

H.43 FEEDING AND NUTRITION: SWALLOWING DISORDERS

Treatment/Monitoring	Performed By	Frequency
☐ Oral Stimulation Program	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Special Diet	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Special Diet Management	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Swallowing Disorders Treatments		

Please provide supporting documentation.

H.44 NEUROLOGICAL: OBSERVATION AND ASSISTANCE FOR SEIZURES

Treatment/Monitoring	Performed By	Frequency
☐ Requires only observation; no physical assistance and | or intervention.	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Requires minimal physical assistance and | or intervention	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Requires significant physical assistance and | or intervention.	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.45 RESPIRATORY

Treatment/Monitoring	Performed By	Frequency
☐ Apnea Monitor	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ CPAP-Via mask	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Nebulizer	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Oxygen Therapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Pulse Oximeter	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ CPAP-Via trach	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Other Treatments

Please provide supporting documentation.

Administration of medical gases

INITIAL phases of a regimen involving administration of medical gases

☐ Yes ☐ No

If **YES** is selected answer the **Performed By** and **Frequency** questions.

Performed By	Frequency
☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

Please provide supporting documentation.

H.46 **BRONCHIAL DRAINAGE**

Treatment/Monitoring	Performed By	Frequency
☐ Respiratory Vest	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Postural Drainage | Pummeling	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Bi-Level	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.47 SUCTIONING

Treatment/Monitoring	Performed By	Frequency
☐ Nasopharyngeal aspiration	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Oral	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Trach aspiration	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Tracheostomy Care	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.48 VENTILATOR

Treatment/Monitoring	Performed By	Frequency
☐ Continuous - expected to be or has been dependent for 3 consecutive days	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Intermittent - at least 6 hours per day and expected to | has been dependent for 3 consecutive days	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Intermittent - not 6 hours per day or not expected to | not been dependent for 3 consecutive days.	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		
☐ Ventilator Care/Maintenance	**Please provide supporting documentation.** ☐ Yes ☐ No **Please provide supporting documentation**	

Comments.

Performed By	Frequency
☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

H.49 VASCULAR: BLOOD DRAW

Treatment/Monitoring	Performed By	Frequency
☐ Blood Glucose - cannula	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Protime| INR (International normalized ratio)	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Dialysis	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.50 VASCULAR: IV THERAPY

Treatment/Monitoring	Performed By	Frequency
☐ Blood Transfusions	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Chemotherapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Medications	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Total Parenteral Nutrition	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Intravenous injections and hypodermoclysis	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

☐ **Intermuscular or subcutaneous injections** if the use of licenses medical personnel is necessary TO TEACH an individual or the individual's caregiver the procedure.

☐ Yes ☐ No

Please provide supporting documentation

Comments.

Performed By	Frequency
☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

H.51 WOUNDS

Treatment/Monitoring	Performed By	Frequency
☐ 2 or 3 Degree burns that require specialized treatment	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Drainage tubes	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Dressing Changes (sterile or clean)	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Open Lesions such as fistulas, tube sites, tumors	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Open Surgical site	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Stage III or IV Decubitus Ulcer	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Wound vac	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.52 SKIN CARE

Treatment/Monitoring	Performed By	Frequency
☐ Application of dressings involving prescription medication and aseptic techniques	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Dry Bandage Change	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Pressure Relieving Device	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Turning | Repositioning Program	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other Treatments		

Please provide supporting documentation.

H.53 **DIAGNOSED MEDICAL CONDITION**

Does the individual have a diagnosed medical condition, which requires monitoring or assessment on a daily basis by a licensed medical professional and does NOT include one of the 11 skilled conditions listed in the Treatment & Monitoring section above?

☐ Yes ☐ No

INPUT CONDITION. THIS MUST BE ANSWERED IF CHOSEN "YES" FOR THE ABOVE DIAGNOSED MEDICAL CONDITION/ MONITORING QUESTION

Therapies

H.54 **Is the person receiving any therapies?** *(This question is related to long term maintenance, not acute therapies.)*

☐ Yes ☐ No ☐ Chose not to answer

Please provide supporting documentation.

Comments

IF H.54 IS YES SELECT THE TYPE OF SKILLED/SPECIALIZED THERAPIES THE CLIENT IS RECEIVING FROM BELOW

LEGEND TABLE

Therapy	Performed By	Frequency
The treatment and monitoring section contain a table. The first column lists the type of therapy performed. Each cell has a checkbox to select the treatment.	The second column in each table contains a drop-down list to indicate who performs or monitors the corresponding treatment. **The choices in the dropdown list include:** • Caregiver/Parent • Nurse/OT/PT/Physician • Direct Care Worker/ST/Certified Nurse Aide • Self	The third column in each table contains a drop-down list that indicates the frequency that the corresponding treatment or monitoring occurs. **The choices in the dropdown list include:** • Daily > 21 Days **for DAAS Only** • Daily <=21 Days • >=30 Days **for DDS Only** • Weekly but not daily • Monthly but not daily

H.55 SKILLED/SPECIALIZED THERAPIES

Therapy	Performed By	Frequency
☐ Alternative Therapies	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Occupational Therapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Pain management	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Physical Therapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Range of Motion	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

☐ Respiratory Therapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Speech Therapy	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ Other	☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily
☐ **Other Skilled/Specialized Therapies**	_____	

Please provide supporting documentation.

H.56 **Heat Treatments**

Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.

☐ Yes ☐ No

Performed By	**Frequency**
☐ Caregiver/Parent ☐ Nurse/OT/PT/Physician ☐ Direct Care Worker/ST/Certified Nurse Aide ☐ Self	☐ Daily > 21 Day Duration for DAAS Only ☐ Daily <= 21 Day Duration ☐ >= 30 Days for DDS Only ☐ Weekly but not daily ☐ Monthly but not daily

H.57 **Rehabilitation Procedures**

Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and NOT AS MAINTENANCE of existing function.

☐ Yes ☐ No

Performed By

☐ Caregiver/Parent
☐ Nurse/OT/PT/Physician
☐ Direct Care Worker/ST/Certified Nurse Aide
☐ Self

Frequency

☐ Daily > 21 Day Duration for DAAS Only
☐ Daily <= 21 Day Duration
☐ >= 30 Days for DDS Only
☐ Weekly but not daily
☐ Monthly but not daily

Please provide supporting documentation.

Comments

Assessment of Pain

H.58 **Is the person CURRENTLY experiencing pain anywhere on their body?**

☐ Yes ☐ No ☐ Chose not to answer

H.59 **Please provide supporting documentation.**

Comments

↓IF H.58 YES, PLEASE COMPLETE THE REMAINDER OF THE PAIN SECTION: ↓

H.60 **How frequently do they experience pain?**

Frequency of pain

H.61 **What is the location of the pain?**

Location of pain

H.62 **Indicate the severity of your pain:**

(Rate 0= No Pain, 10 = Worst Pain Imaginable)

Severity of pain

H.63 **How does the person manage their pain?**

I. Psychosocial

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Injurious to Self

I.1 **Person engages in, or would without an intervention, behavior that causes physical harm or has significant potential for causing physical harm to their own body. Includes putting self in dangerous situations.**

☐ Yes ☐ No

↓ IF I.1 IS YES, PLEASE COMPLETE THE REMAINDER OF THE INJURIOUS TO SELF SECTION: ↓

I.2 **In what types of physical harm to self do they engage? Select all that apply.**

- ☐ Chemical abuse/misuse
- ☐ Head-banging
- ☐ Pulling out hair
- ☐ Puts self in dangerous situations that causes harm or injury
- ☐ Self-burning
- ☐ Self-biting/cutting/hitting/poking/ or stabbing
- ☐ Self restricts eating
- ☐ Other

Other types of self-harm:

(Any other types of self harm)

I.3 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.4) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.4 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Aggressive Toward Others, Physical

I.5 **Person engages in, or would without an intervention, behavior that causes physical harm to other people or to animals. A person who causes physical harm due to involuntary movement is not considered to have physical aggression towards others.**

☐ Yes ☐ No

↓IF I.5 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGGRESSIVE TOWARD OTHERS, PHYSICAL SECTION↓:

I.6 **What types of physical aggression toward others do they engage? Select all that apply.**

- ☐ Bites
- ☐ Hits/Punches/Kicks
- ☐ Pulls others hair
- ☐ Pushes
- ☐ Scratches
- ☐ Throws objects at others
- ☐ Touches others in a sexual manner against their will
- ☐ Uses objects to hurt others
- ☐ Other

Other types of physical aggression:

(Any other types of physical aggression. Please provide supporting documentation.)

I.7 **Intervention: Support and/or services provided by staff and/or caregiver for aggression**

- ☐ Requires no intervention **(if selected, frequency question (I.8) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.8 **How often on a weekly basis is intervention needed for aggression?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Aggressive Toward Others, Verbal Gestural

I.9 **Person engages in, or would without an intervention, the use language verbally, through written words or symbols, or non-verbally through facial expressions, gestures or signs which threaten psychological, emotional or physical harm towards others.**

☐ Yes ☐ No

↓IF I.9 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGGRESSIVE TOWARD OTHERS, VERBAL/GESTURAL SECTION:↓

I.10 **What types of verbal/gestural aggression toward others do they display? Select all that apply.**

- ☐ Attempts to intimidate through aggressive gestures with no physical contact
- ☐ Goading/Intimidation/Staring
- ☐ Resistive to care
- ☐ Swears/yells/screams at others/verbal threats
- ☐ Taunting/Teasing
- ☐ Writes threatening notes
- ☐ Other

Other types of verbal/gestural aggression:

(Any other types of verbal/gestural aggression)

I.11 **Intervention: Support and/or services provided by staff and/or caregiver for aggressive nature Toward Others, Verbal/Gestural**

- ☐ Requires no intervention **(if selected, frequency question (I.12) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.12 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Socially Unacceptable Behavior

I.13 **Person expresses themselves, or would without an intervention, in an inappropriate or unacceptable manner including sexual, offensive or injurious to self with others. Includes behavior (verbal/ non-verbal) that draws negative attention to themselves.**

☐ Yes ☐ No

↓IF I.13 IS YES PLEASE COMPLETE THE REMAINDER OF THE SOCIALLY UNACCEPTABLE BEHAVIORS SECTION. ↓

I.14 **Type of Socially Unacceptable Behavior Displayed: Select all that apply.**

- ☐ Disruptive of other's activities
- ☐ Doesn't understand personal boundaries
- ☐ Spitting
- ☐ Throws food
- ☐ Urinating/Defecating in inappropriate places
- ☐ Other
- ☐ Other – Socially offensive behavior
- ☐ Exposes private body areas to others
- ☐ Inappropriate touching of others
- ☐ Masturbates in public
- ☐ Other - Inappropriate sexual activities

Other types of unacceptable behavior:

_____

(Any other types of unacceptable behavior)

I.15 **Intervention: Support and/or services provided by staff and/or caregiver for socially unacceptable behavior.**

- ☐ Requires no intervention **(if selected, frequency question (I.16) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.16 **How often on a weekly basis is intervention needed for socially unaccepted behavior?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Property Destruction

I.17 **Person engages in behavior, or would without an intervention, to intentionally disassemble, damage or destroy public or private property or possessions.**

☐ Yes ☐ No

I.18 **Type of Property Destruction: Select all that apply**

☐ Breaks windows, glasses, lamps or furniture ☐ Uses tools/objects to damage property
☐ Sets fires ☐ Other

Other types of property destruction:

(Any other types of property destruction)

I.19 **Intervention: Support and/or services provided by staff and/or caregiver for property destruction.**

☐ Requires no intervention **(if selected, frequency question (I.20) is not asked)**
☐ Needs interventions in the form of cues - responds to cues
☐ Needs redirection - responds to redirection
☐ Needs behavior management or instruction - resists redirection/intervention
☐ Needs behavior management or instruction - physically resists intervention

I.20 **How often on a weekly basis is intervention needed for property destruction behavior?**

☐ Less than weekly ☐ Three times per week
☐ One time per week ☐ Four or more times per week but not daily
☐ Two times per week ☐ Daily

Wandering/ Elopement

I.21 **Person purposefully will, or would without an intervention, leave an area or group without telling others or depart from the supervision staff unexpectedly resulting in increased vulnerability.**

☐ Yes ☐ No

↓IF I.21 IS YES, PLEASE COMPLETE THE REMAINDER OF THE WANDERING/ELOPEMENT SECTION↓

I.22 **Type of Wandering/Elopement Behaviors Displayed: Select all that apply.**

☐ Intentionally wanders away from staff while in the community
☐ Leaves living area for extended period of time without informing appropriate person
☐ Runs away
☐ Other

Other types of wandering behavior:

(Any other types of wandering behavior)

I.23 **Intervention: Support and/or services provided by staff and/or caregiver for wandering**

- ☐ Requires no intervention **(if selected, frequency question (I.24) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.24 **How often on a weekly basis is intervention needed for wandering?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Legal Involvement

I.25 **Person has been arrested and convicted of breaking a law or laws.**

☐ Yes ☐ No

↓ IF I.25 IS YES, PLEASE COMPLETE THE REMAINDER OF THE LEGAL INVOLVEMENT SECTION: ↓

I.26 **Types of Legal Involvement Behaviors Displayed: Select all that apply.**

- ☐ Assault
- ☐ Burglary
- ☐ Commits arson
- ☐ Drug related crimes
- ☐ Financial crimes/stealing/compulsive spending
- ☐ Prostitution
- ☐ Public nuisance
- ☐ Sexual crimes
- ☐ Shoplifting
- ☐ Terroristic threats
- ☐ Trespassing
- ☐ Other

Other types of legal involvement:

_____

(Any other types of legal involvement)

I.27 **Intervention: Support and/or services provided by staff and/or caregiver in legal involvement**

- ☐ Requires no intervention **(if selected, frequency question (I.28) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.28 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

PICA (Ingestion of Non-Nutritive Substances)

I.29 **Person will ingest or would without an intervention, inedible items such as paper, strings, dirt or toilet water that may cause physical harm to that person.**

☐ Yes ☐ No

↓ IF I.29 IS YES, PLEASE COMPLETE THE REMAINDER OF THE PICA SECTION:↓

I.30 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.31) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.31 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Comments

Susceptibility to Victimization

I.32 **Person engages in, or would without an intervention, behaviors that increase or could potentially increase a person's level of risk or harm or exploitation by others such as befriending strangers.**

☐ Yes ☐ No

I.33 **How is person susceptible to victimization? Select all that apply.**

- ☐ Caregiver neglect
- ☐ Domestic abuse
- ☐ Financial exploitation
- ☐ Person easily manipulated to their detriment
- ☐ Physical exploitation
- ☐ Physically threatened
- ☐ Puts self in harm's way
- ☐ Sexual exploitation
- ☐ Other

Other types of susceptibility to victimization:

(Any other types of susceptibility to victimization)

I.34 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.39) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.35 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Withdrawal

I.36 **Person has a tendency, or would without an intervention, to avoid, isolate or retreat from conversation, interaction or activity.**

☐ Yes ☐ No

↓ IF I.36 IS YES, PLEASE COMPLETE THE REMAINDER OF THE WITHDRAWAL SECTION: ↓

I.37 **Types of Withdrawal Behaviors Displayed:**

- ☐ Avoidance
- ☐ Isolation
- ☐ Lack of interest in life's events
- ☐ Other

Other types of withdrawal behaviors:

(Any other types withdrawal behaviors)

I.38 **Intervention: Support and/or services provided by staff and/or caregiver for withdrawal behavior.**

- ☐ Requires no intervention **(if selected, frequency question (I.39) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.39 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Agitation

I.40 **Person has a tendency, or would without an intervention, to suddenly or quickly become upset or violent.**

☐ Yes ☐ No

↓ IF I.40 IS YES, PLEASE COMPLETE THE REMAINDER OF THE AGITATION SECTION:↓

I.41 **Types of Agitation Behaviors Displayed: Select all that apply.**

- ☐ Easily agitated / Easily angered
- ☐ Easily frustrated
- ☐ Other

Other types of agitation behaviors:

_____

(Any other types of agitation behaviors)

I.42 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.43) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.43 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Impulsivity

I.44 **Person has a propensity, or would without an intervention, for sudden or spontaneous decisions or actions.**

☐ Yes ☐ No

↓ IF I.44 IS YES, PLEASE COMPLETE THE REMAINDER OF THE IMPULSIVITY SECTION:↓

I.45 **Types of Impulsive Behaviors Displayed: Select all that apply.**

- ☐ Disregard for personal safety
- ☐ Easily influenced by others
- ☐ Financial
- ☐ High risk behaviors
- ☐ Thoughtless about boundaries
- ☐ Other

Other types of impulsive behaviors:

_____

(Any other types of impulsive behaviors)

I.46 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.47) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.47 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Intrusiveness

I.48 **Person has a tendency, or would without an intervention, for entering personal or private space without regard or permission.**

☐ Yes ☐ No

↓ IF I.48 IS YES, PLEASE COMPLETE THE REMAINDER OF THE INTRUSIVENESS SECTION: ↓

I.49 **Types of Intrusive Behaviors Displayed: Select all that apply.**

- ☐ Inappropriate boundaries in public/private areas
- ☐ Physical
- ☐ Verbal
- ☐ Unawareness of interpersonal space
- ☐ Other

Other types of intrusive behaviors

_____

(Any other types of intrusive behaviors)

I.50 **Intervention: Support and/or services provided by staff and/or caregiver.**

- ☐ Requires no intervention **(if selected, frequency question (I.51) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.51 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Injury to Others, Unintentional

I.52 **Person engages in behavior, or would without an intervention, that causes actual injury to others that is unintentional, including hitting and punching.**

☐ Yes ☐ No

↓ IF YES, PLEASE COMPLETE THE REMAINDER OF THE INJURY TO OTHERS-UNINTENTIONAL SECTION:↓

I.53 **Types of Injury to Others:**

- ☐ Unintentional
- ☐ Other

Other types of injury to others:

_____

(Any other types of injury to others:)

I.54 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.55) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.55 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Anxiety

I.56 **An overwhelming feeling of apprehension and nervousness characterized by physical symptoms such as sweating and panic attacks. Worry, over-concern or restlessness due to fear that prevents the individual from doing things they want to do.**

☐ Yes ☐ No

I.57 **Types of Anxious Behaviors Displayed: Select all that apply.**

- ☐ Avoidance of people/situations
- ☐ Easily triggered due to past trauma
- ☐ Hoarding
- ☐ Hyper-vigilance
- ☐ Inability to concentrate
- ☐ Phobias due to fear
- ☐ Rocking
- ☐ Other

Other types of anxious behaviors:

_____

(Any other types of anxious behaviors)

I.58 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.59) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.59 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Psychotic Behaviors: if age<=17 consult with supervisor before selecting yes

I.60 **Markedly inappropriate behavior that affects a person's daily functioning and social interactions. Behavior characterized by a radical change in personality and a distorted or diminished sense of reality**.

☐ Yes ☐ No

↓ IF I.60 IS YES, PLEASE COMPLETE THE REMAINDER OF THE PSYCHOTIC BEHAVIORS SECTION: ↓

I.61 **Types of Psychotic Behaviors Displayed: Select all that apply.**

- ☐ Catatonic behavior
- ☐ Delusions
- ☐ Disorganized speech
- ☐ Hallucinations
- ☐ Thought disorder
- ☐ Other

Other types of psychotic behaviors:

(Any other types of psychotic behaviors:)

I.62 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.63) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.63 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Manic Behaviors: If age= <17 consult with supervisor before selecting yes

I.64 **Elevated changes in mood states characterized by severe fluctuations in energy and activity level, inappropriate elation and grandiose notions. Manic behavior patterns include hyperactivity, increased energy and heightened mood.**

☐ Yes ☐ No

↓IF I.64 IS YES, PLEASE COMPLETE THE REMAINDER OF THE MANIC BEHAVIORS SECTION: ↓

I.65 **Types of Manic Behaviors Displayed: Select all that apply.**

- ☐ Decreased need for sleep
- ☐ Distractibility
- ☐ Grandiosity
- ☐ Inflated self-esteem
- ☐ Rapid/intense speech inappropriate to situation
- ☐ Other

Other types of manic behaviors

(Any other types of manic behaviors)

I.66 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.67) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.67 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Difficulties Regulating Emotions

I.68 **Person has instances, or would without an intervention, of emotional behavior that are atypical of others in similar situations.**

☐ Yes ☐ No

↓IF I.68 IS YES, PLEASE COMPLETE THE REMAINDER OF THE DIFFICULTIES REGULATING EMOTIONS SECTION

I.69 **Check all that apply:**

- ☐ Cries
- ☐ Frequently argues about small things
- ☐ Impulsivity
- ☐ Isolation
- ☐ Over excitement
- ☐ Overzealous social exchanges
- ☐ Screams
- ☐ Shouts angrily
- ☐ Tantrums
- ☐ Throws self on floor
- ☐ Other

Other difficulties in regulating emotions:

_____

(Any other difficulties in regulating emotions)

I.70 **Intervention: Support and/or services provided by staff and/or caregiver**

- ☐ Requires no intervention **(if selected, frequency question (I.71) is not asked)**
- ☐ Needs interventions in the form of cues - responds to cues
- ☐ Needs redirection - responds to redirection
- ☐ Needs behavior management or instruction - resists redirection/intervention
- ☐ Needs behavior management or instruction - physically resists intervention

I.71 **How often on a weekly basis is intervention needed?**

- ☐ Less than weekly
- ☐ One time per week
- ☐ Two times per week
- ☐ Three times per week
- ☐ Four or more times per week but not daily
- ☐ Daily

Patient Health Questionnaire (PHQ-2) (Ages 18-64)

During the last two weeks, have you often been bothered

I.72 **By having little interest or pleasure in doing things?**

☐ Yes ☐ No

I.73 **By feeling down, sad or hopeless?**

☐ Yes ☐ No

↓IF EITHER I.72 OR I.73 IS YES, ANSWER PHQ-9 BELOW. ↓

Patient Health Questionnaire (PHQ-9) (Ages 18-64)

Over the last two weeks, how often have you been bothered of little interest or pleasure in things?
Answer this if response for any of PHQ- 2 is Yes

I.74 **Little interest or pleasure in doing things.**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.75 **Feeling down, depressed, or hopeless.**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.76 **Trouble falling or staying asleep or sleeping too much.**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.77 **Feeling tired or having little energy**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.78 **Poor appetite or overeating**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.79 **Feeling bad about yourself**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.80 **Trouble concentrating on things**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.81 **Moving or speaking so slowly**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

I.82 **Thoughts that you would be better off dead**
☐Not at all ☐More than half the days
☐Several Days ☐Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐Not difficult at all ☐Very difficult
☐Somewhat difficult ☐Extremely difficult

Geriatric Depression Scale -Preceptor (Age 65+)

During the last two weeks, have you often been bothered?

I.83 **By about having little interest in doing things?**
☐ Yes ☐ No

I.84 **By feeling down, sad or hopelessness?**
☐ Yes ☐ No

↓IF EITHER ANSWER IS YES, ANSWER THE QUESTIONS BELOW. ↓

Geriatric Depression Scale (Age 65+)

During the last two weeks, have you often been bothered?

I.85 **Are you basically satisfied with your life?**
☐ Yes ☐ No

I.86 **Have you dropped many of your activities?**
☐ Yes ☐ No

I.87 **Do you feel that your life is empty?**
☐ Yes ☐ No

I.88 **Do you often get bored?**
☐ Yes ☐ No

I.89 Are you in good spirits most of the time?
☐ Yes ☐ No

I.90 **Been bothered of being afraid of something bad?**
☐ Yes ☐ No

I.91 **Do you feel happy most of the time?**
☐ Yes ☐ No

I.92 **Do you often feel helpless?**
☐ Yes ☐ No

I.93 **Prefer to stay at home, then go out?**
☐ Yes ☐ No

I.94 **Do you feel you have more problems with memory than most?**
☐ Yes ☐ No

I.95 **Do you think it is wonderful to be alive now?**
☐ Yes ☐ No

I.96 **Do you feel pretty worthless?**
☐ Yes ☐ No

I.97 **Do you feel full of energy?**
☐ Yes ☐ No

I.98 **Do you feel that your situation is hopeless?**
☐ Yes ☐ No

I.99 **Do you think that most people are better off than you are?**
☐ Yes ☐ No

Pediatric Symptom Checklist (PSC-17) (Ages 4 – 17)

I.100 **Have you or another caregiver ever completed a Pediatric Symptom Checklist form at school or in a physician's office?**
☐ Yes ☐ No ☐ Unsure

↓IF ANSWER IS NO OR UNSURE, ASK THE QUESTIONS BELOW. ↓

I.101 **Fidgety, unable to sit still**
☐ Never ☐ Sometimes ☐ Often

I.102 **Feels sad, unhappy**
☐ Never ☐ Sometimes ☐ Often

I.103 **Daydreams too much**
☐ Never ☐ Sometimes ☐ Often

I.104 **Refuses to share**
☐ Never ☐ Sometimes ☐ Often

I.105 **Does not understand other people's feelings**
☐ Never ☐ Sometimes ☐ Often

I.106 **Feels hopeless**
☐ Never ☐ Sometimes ☐ Often

I.107 **Has trouble concentrating**
☐ Never ☐ Sometimes ☐ Often

I.108 **Fights with other children**
☐ Never ☐ Sometimes ☐ Often

I.109 **Is down on him or herself**
☐ Never ☐ Sometimes ☐ Often

I.110 **Blames others for his/her troubles**
☐ Never ☐ Sometimes ☐ Often

I.111 **Seems to be having less fun**
☐ Never ☐ Sometimes ☐ Often

I.112 **Does not listen to rules**
☐ Never ☐ Sometimes ☐ Often

I.113 **Acts as if driven by a motor**
☐ Never ☐ Sometimes ☐ Often

I.114 **Teases others**
☐ Never ☐ Sometimes ☐ Often

I.115 **Worries a lot**
☐ Never ☐ Sometimes ☐ Often

I.116 **Takes things that do not belong to him/her**
☐ Never ☐ Sometimes ☐ Often

I.117 **Distracted easily**
☐ Never ☐ Sometimes ☐ Often

Suicide Screen

I.118 **Have you thought about hurting yourself or taking your life?**

☐ No
☐ Person unable to respond or refuses to answer
☐ Yes-now
☐ Yes-within last 30 days
☐ Yes - greater than 30 days

IF "YES-NOW" OR "YES – WITHIN LAST 30 DAYS" ARE SELECTED FOR I.118, ASK THE REMAINDER OF THE SUICIDE SCREEN SECTION:

I.119 **Do you have a plan?**

☐ No
☐ Yes – contact a mental health professional immediately
☐ Person unable to respond or refused to answer

I.120 **Do you have the means or some way to carry out your plan?**

☐ No
☐ Yes – contact a mental health professional immediately
☐ Person unable to respond or refused to answer

I.121 **Do you have a time planned that you will do this?**

☐ No
☐ Yes – contact a mental health professional immediately
☐ Person unable to respond or refused to answer

Alcohol/Substance Abuse (Age >=12)

I.122 **Do you currently drink alcoholic beverages like beer, wine or liquor?**

☐ No
☐ Yes
☐ Sometimes
☐ Choose not to answer

IF "YES" OR "SOMETIMES" ARE SELECTED FOR I.122, ASK THE REMAINDER OF THE ALCOHOL USE SECTION:

I.123 **How frequently do you drink alcoholic beverages?**

☐ Daily
☐ 1-3 times per week
☐ 4-6 times per week
☐ Once a month or less
☐ Rarely
☐ Chose not to answer

I.124 **Within the last year, has drinking affected your job, family life and friendships or caused legal problems?**

☐ Yes ☐ No ☐ Choose not to answer

If yes, please explain *(Please provide supporting documentation of substance, amount, and frequency.)*

↓ If "Yes" answered for I.124 above, ask the Alcohol CAGE questions below: ↓

Alcohol CAGE Questionnaire

I.125 **Have you felt you should cut down on your drinking?**

☐ No ☐ Yes ☐ Chose not to answer

I.126 **Have people annoyed you by criticizing your drinking?**

☐ No ☐ Yes ☐ Chose not to answer

I.127 **Have you ever felt bad or Guilty about your drinking?**

☐ No ☐ Yes ☐ Chose not to answer

I.128 **Have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?**

☐ No ☐ Yes ☐ Chose not to answer

Substance Abuse (Age 12+)

I.129 **Does the person currently use any street/illegal drugs (i.e. methamphetamine, speed, marijuana) or misuse/abuse prescription?**

☐ No ☐ Yes ☐ Sometimes ☐ Chose not to answer

I.130 **Within the last year, has your substance use affected your job, family life and friendships or caused legal problems?**

☐ No ☐ Yes ☐ Chose not to answer

If yes, please explain *(Please provide supporting documentation of substance, amount, and frequency)*

IF "YES" ANSWERED FOR I.130 ABOVE, ASK THE SUBSTANCE ABUSE CAGE QUESTIONS BELOW:

I.131 **Have you felt you should Cut down on your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.132 **Have people annoyed you by criticizing your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.133 **Have you ever felt bad or Guilty about your drug use?**

☐ No ☐ Yes ☐ Chose not to answer

I.134 **Have you gotten high first thing in the morning to steady your nerves or to help you feel better (eye opener)?**

☐ No ☐ Yes ☐ Chose not to answer

J. Memory & Cognition

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Functional Memory & Cognition

J.1 **Does the person have a problem with cognitive functioning due to developmental disabilities or related condition, which manifested itself during the developmental period (birth through age 21) by report or by review of psychological testing results?**

☐ No ☐ Undetermined ☐ Yes – Due to developmental disabilities

J.2 **If Undetermined, Referral for testing?**

☐ Need referral ☐ Referral made - waiting testing results

J.3 **Does the person have a documented diagnosis of brain injury or related neurological condition that is not congenital?**

☐ No ☐ Yes

IF YES ANSWERED FOR J.3 ABOVE, CHOOSE ONE FROM J.4 BELOW

J.4 **Choose one:**

☐ Acquired or traumatic brain injury

☐ Degenerative or genetic disease that became symptomatic on or after the person's 18th birthday

J.5 **What is the diagnosis**?

Diagnosis

J.6 **Rancho Los Amigos Level of Cognitive Fn? Only complete if client has traumatic or acquired brain injury.**

☐ Person is completely unresponsive to stimuli

☐ Person reacts inconsistently and non-purposefully to stimuli

☐ Person responds specifically but inconsistently to stimuli and may follow simple commands

☐ Person is in a heightened state of activity with severely decreased ability to process information. Behavior is non-purposeful relative to the immediate environment.

☐ Person appears alert and responds to simple commands fairly consistently. Agitation, which is out of proportion (But directly related to stimuli), may be evident.

☐ Person shows goal directed behavior but depends on external input for direction

☐ Person goes through daily routine automatically, has absent to minimal confusion, but lacks insight

☐ Person is alert and oriented. Independence in the home and community has returned. Social, emotional and cognitive abilities may be decreased.

Notes/Comments

Mental Status Evaluation

J.7 **Now, I'm going to read you a list of questions. These are questions that are often asked in interviews like this, and we are asking them the same way to everyone. Some may be easy, and some may be difficult. Would this be alright?**

☐ No ☐ Yes ☐ Refused

IF YES, FOR EACH OF THE QUESTIONS BELOW, ENTER THE NUMBER OF ERRORS THE INDIVIDUAL MAKES. PLEASE NOTE THE MAXIMUM ALLOWED FOR EACH QUESTION

J.8 **LET'S START WITH TODAY'S DATE. What year is it now? Maximum Error = 1**

- ☐ Answered Correctly
- ☐ Answered Incorrectly

J.9 **What month is it now? Maximum Error = 1**

- ☐ Answered Correctly
- ☐ Answered Incorrectly

J.10 **Memory Phase: Ask beneficiary to repeat phrase after you TWICE:**

John Brown, 42 Market Street, Chicago

J.11 **About what time is it? (within 1 hour) Maximum errors = 1**

- ☐ Answered Correctly
- ☐ Answered Incorrectly

J.12 **Count backwards 20 to 1 Maximum Errors = 2**

- ☐ Answered Correctly
- ☐ Answered Incorrectly
- ☐ Answered Incorrectly Twice

J.13 **Say the months in reverse order. Maximum Errors = 2**

- ☐ Answered Correctly
- ☐ Answered Incorrectly Once
- ☐ Answered Incorrectly Twice

J.14 **Ask beneficiary to repeat memory phrase above**

Repeat the memory phrase (once) **Maximum Errors = 5**

- ☐ Answered Correctly
- ☐ Answered Incorrectly Once
- ☐ Answered Incorrectly Twice
- ☐ Answered Incorrectly Thrice
- ☐ Answered Incorrectly 4 times
- ☐ Answered Incorrectly 5 times

Please provide supporting documentation.

Comments

Types of Supports Needed

J.15 **What type of support does the person need <u>in the home</u> to remain safe, such as assistance with activities that require remembering, decision-making or judgment?**

☐ Someone else needs to be with the person always to observe or provide supervision.

☐ Someone else needs to be around always, but they only need to check on the person now and then.

☐ Sometimes the person can be left alone for an hour or two.

☐ Sometimes the person can be left alone for most of the day.

☐ The person can be left alone all day and all night, but someone needs to check in on the person every day.

☐ The person can be left alone without anyone checking in.

J.16 **What type of support does the person need <u>away from home</u> to remain safe, such as assistance with activities that require remembering, decision-making, or judgment?**

☐ The person requires intense support when leaving home because of behavioral difficulties (becomes very confused or agitated during outings, engages in inappropriate behavior, becomes aggressive etc.)

☐ Someone always needs to be with the person to help with remembering, decision making or judgment when away from home.

☐ The person can go places alone as long as they are familiar places

☐ The person does not need help going anywhere

Please provide supporting documentation.

Comments

K. Sensory & Communication

Return to Index

Vision

K.1 **Does the person have any problems with their vision?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.1 IS YES, PLEASE COMPLETE THE REMAINDER OF THE VISION SECTION:

K.2 **Describe your vision WITHOUT the use of an assistive device**.

☐ *Adequate:* Can read regular print in books or newspapers

☐ *Minimally Limited:* Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print.

☐ *Moderately Limited:* Must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation.

☐ *Severely Limited:* Sees primary lights and shadows; has significantly restricted field vision; or no useful vision.

K.3 **Does the person use any assistive device to help with their vision?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.3 IS YES, ASK K.4 BELOW

K.4 **Describe your vision WITH the use of an assistive device.**

☐ *Adequate:* Can read regular print in books or newspapers

☐ *Minimally Limited:* Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print

☐ *Moderately Limited:* Must have large print to read'; has difficulty identifying small objects; vision has limited usefulness for navigation

☐ *Severely Limited:* Sees primary lights and shadows; has significantly restricted field vision; or no useful vision

Please provide supporting documentation.

Comments

K.5 **Does the person have any problems with their hearing?**

☐ No ☐ Yes ☐ Chose not to answer

K.6 **Describe your hearing WITHOUT use of an assistive device.**

☐ *Normal*

☐ *Minimally Impaired*: Difficulty in 1:1 conversation with some people and/or in noisy environments.

☐ *Moderately Impaired*: Some useful hearing; using own speech to make needs and wants known.

☐ Highly Impaired: May hear loud sounds; identifying source and allocation of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television)

☐ *Severely Impaired*: No useful hearing

☐ *Unknown*

K.7 **Does the person use any assistive devices to help with their hearing**?

☐ No

☐ No-uses interpreter

☐ Yes

☐ Chose not to answer

K.8 **Describe your hearing WITH use of an assistive device**.

☐ *Normal*

☐ *Minimally Impaired* – difficulty 1:1 conversation with some people and/or in noisy environments.

☐ *Moderately Impaired* – Overall useful hearing; uses own speech to make needs and wants known.

☐ *Highly Impaired* – may not hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding (sign language, written language, speech reading, captioning on television)

☐ *Severely Impaired* – No useful hearing.

Please provide supporting documentation.

Comments

Functional Communication

K.9 **Does the person have difficulty communicating with and | or making their wants and needs known to others?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.9 IS YES, PLEASE COMPLETE THE REMAINDER OF THE FUNCTIONAL COMMUNICATION SECTION:

K.10 **What type of difficulty does the person have? (check all that apply):**

☐ Delayed expressive language
☐ No functional communication
☐ No functional expressive language
☐ Non-verbal
☐ Receptive language impairment (inability to comprehend spoken language)
☐ Speech impairment (articulation)
☐ Speech impairment (functional expressive language

K.11 **What is the primary cause of the difficulties you identified?**

☐ Cognitive issues (delayed | disordered development)
☐ Deaf
☐ Motor issues (cerebral palsy, act)
☐ Neurological issues (e.g., seizures, aphasia, apraxia)
☐ Physical | medical issues (e.g., after a laryngectomy)
☐ Other

Please provide supporting documentation.

If Other, please explain

K.12 **Expressive Communication Skills** *(How does the person communicate with others? This means their functional ability to communicate with others.)*

- ☐ No impairment
- ☐ Speech intelligible to familiar listeners
- ☐ Speech difficult to understand
- ☐ Combines signs and | or gestures to communicate
- ☐ Uses single signs or gestures to express wants and needs
- ☐ Uses augmentative communication
- ☐ Does not have functional expressive language

K.13 **Receptive Communication Skills** *(How does the person understand others? This means their functional ability to understand others.)*

- ☐ Comprehends conversational Speech
- ☐ Comprehends phrases with gestural cues | modeling prompts
- ☐ Limited Comprehension - one or two words
- ☐ Comprehends signs | gestures | modeling prompts
- ☐ Does not comprehend verbal, visual or gestural communication

Please provide supporting documentation.

Comments

K.14 **Does the person currently receive speech and language therapy?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

Comments

IF K.14 IS YES, ASK K.15 BELOW:

K.15 **Does the person use some form of sign language to communicate?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.15 IS YES, ASK K.16 BELOW:

K.16 **What types of sign language do you use?**

- ☐ American Sign Language
- ☐ Baby sign
- ☐ Emoticon+Bodicon (Facial expression + body language)
- ☐ Home signs, gestures
- ☐ International sign language
- ☐ Limited or Close Vision Signing
- ☐ Manual alphabet (finger spelling)
- ☐ Signed English
- ☐ Tactile (hand in hand) signing
- ☐ Other

Please provide supporting documentation.

If Other, please explain

K.17 **Does the person use visual language, other than sign language to communicate?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.17 IS YES, ASK K.18 BELOW:

K.18 **What type?**

- ☐ Cued speech
- ☐ Speech reading
- ☐ Writing or typing
- ☐ Other

Please provide supporting documentation.

If Other, please explain

K.19 **Facilitated communication (also known as supported typing) is a form of augmentative and alternative communication in which someone PHYSICALLY SUPPORTS ANOTHER PERSON and helps them to point at pictures or words**.

☐ No ☐ Yes ☐ Chose not to answer

K.20 **Uses augmentative communication device? This includes methods to supplement or replace speech or writing for those with impairments in speaking or comprehending spoken or written language.**

☐ No ☐ Yes ☐ Chose not to answer

IF K.20 IS YES, ASK K.21 BELOW:

K.21 **What type of device?**

- ☐ Alpha Smart
- ☐ Alpha Talker
- ☐ Artificial Larynx
- ☐ Big mac Switch
- ☐ Braille Screen Communicator
- ☐ Cheap talk
- ☐ Dynamite
- ☐ Dynavox
- ☐ Electric output device
- ☐ Link Assistive Device
- ☐ Mini Message Mate
- ☐ PECS
- ☐ Pocket Talker
- ☐ Speak Easy
- ☐ TTY
- ☐ Voice Photo Album
- ☐ Voice Recognition Software
- ☐ Other Personal Listing Device
- ☐ Other picture systems
- ☐ Other

Please provide supporting documentation.

If Other, please explain

K.22 **Condition where multisensory integration is not adequately processed in order to provide appropriate responses to the demands of the environment, making it difficult to use the body effectively within the environment.**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

K.23 **Does the person have a Hypersensitivity Diagnosis – are they overly sensitive to sensory stimulation (touch, taste, smell, movement, hearing, vision)?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

K.24 **Does the person use assistive devices or other interventions help with sensory integration?**

☐ No ☐ Yes ☐ Chose not to answer

IF K.24 IS YES, CHECK ALL THAT APPLY FOR K.25 BELOW:

K.25 **Check all that apply**.

- ☐ Noise cancelling headphones
- ☐ Occupational therapy
- ☐ Safety ear plugs
- ☐ Sensory diet / menu for gaining behavioral control
- ☐ Other device
- ☐ Other intervention

Please provide supporting documentation.

If Other device, please explain

Please provide supporting documentation.

If Other intervention, please explain

K.26 **Any issues related to sensory input? Does the person experience any of the following issues related to sensory input?**

- ☐ Appear to hear adequately, but have a delayed response to sounds / speech
- ☐ Can't keep hands to self
- ☐ Difficulty keeping tongue in mouth, put hands/fingers in mouth frequently
- ☐ Difficulty making transitions from one situation to another
- ☐ Difficulty screening out sights and sounds (visual/auditory stimuli)
- ☐ Difficulty unwinding or calming self
- ☐ Engage in self-injury
- ☐ Engage in self-stimulation
- ☐ Fearful of activities moving through space, such as using an escalator, climbing stairs, etc.
- ☐ Fearful of new tasks and situations
- ☐ Grind, clench teeth
- ☐ Make repetitive vocal sounds – such as humming, throat-clearing, frequent coughing
- ☐ Misjudge force required to open and close doors, give hugs, etc.
- ☐ More clumsy or careless than peers
- ☐ Overly sensitive to touch, movement, sights, lights, or sounds
- ☐ Poor balance
- ☐ Prefer activities that involve swinging, spinning, rocking
- ☐ Reject textures of food, clothing
- ☐ Respond to loud or unexpected noise by becoming upset
- ☐ Rock self to sleep, in frustration, in comfort, in excitement
- ☐ Smell objects
- ☐ Under-reactive to touch, movement, sights, or sounds
- ☐ Unusually high activity level
- ☐ Unusually low activity level
- ☐ Unusual reaction to pain – doesn't seem to notice
- ☐ Unusual reaction to pain – particularly noticeable reaction
- ☐ Walk on toes
- ☐ Other

Please provide supporting documentation.

If Other, please explain

L. Safety/Self Preservation

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Self-Preservation: Consider age appropriateness when answering all questions

L.1 **BH Assessments ONLY- Does the person requires a 24-hour plan of care that includes a back-up plan that reasonably assures their health and safety in the community?**

- ☐ No – Person accesses supports as needed
- ☐ No – Person requires some services; doesn't require a 24-hour Plan of Care
- ☐ Yes
- ☐ Unknown

↓IF L.1 IS YES, ASK L.2 BELOW AND COMPLETE. ↓

L.2 **BH Assessments ONLY - Which of the following items does the 24-Hour Plan require?**

- ☐ Awake supervision
- ☐ Formal behavior support

L.3 **Does the person have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?**

- ☐ Independent
- ☐ Minimal supervision (verbal/physical prompts for preservation)
- ☐ Mentally unable
- ☐ Physically unable
- ☐ Both mentally and physically unable

L.4 **This person is at risk of self-neglect?**

(Consider the examples below under Check all that apply. In the absence of a guardian or other person, would this client be at risk of neglecting self?)

☐ No ☐ Yes

L.5 **Check all that apply:**

- ☐ Alcohol and/or other drug use leading to health or safety concerns
- ☐ Behaviors that pose a threat of harm to self or others
- ☐ Dehydration or malnutrition
- ☐ Hygiene that may compromise health
- ☐ Impairment of orientation, memory, reasoning and/or judgment
- ☐ Inability to manage funds that may result in negative consequences
- ☐ Inability to manage medications or to seek medical treatment that may threaten health or safety
- ☐ Unsafe/unhealthy living conditions
- ☐ Other

L.6 **This person is at risk of neglect, abuse by others?**

(This is due to the fact that the client must rely on someone else for self-care (including living in an institutional setting), thus placing them at risk of abuse, neglect, or exploitation.)

☐ No ☐ Yes

Other type of risk of self-neglect

Please provide supporting documentation.

M. Caregiver

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M.1

First and Last Name

M.2 **Relationship**

(For DDS Population, If the value of Subdivision 5 or 6 Intermediate Care Facility is selected in the Relationship field, no need to fill rest of questions, please save record)

☐ Parent
☐ Child
☐ Spouse/Significant Other/Partner
☐ Guardian/Legal Representative
☐ Subdivision 5 or 6 Intermediate Care Facility
☐ Other

Please provide supporting documentation.

If Other, please explain

M.3 **Does client receive 24-hour 7 days a week one-on-one direct care staff under the waiver or personal care services?**

☐ Yes
☐ No
☐ Not applicable: BH
☐ Not applicable: DAAS

M.4 **Does the unpaid caregiver currently live in the same household as the INDIVIDUAL who needs care?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

M.5 **What kind of help does the unpaid caregiver give this individual?**

- ☐ None
- ☐ Arranging | Coordinating care, including clinic visits, etc.
- ☐ Housekeeping (such as meal preparation, cleaning & laundry)
- ☐ Managing medications (like helping set up)
- ☐ Money management
- ☐ Monitoring health (like blood pressure or diabetes
- ☐ Paperwork like filing insurance claims or handling legal matter
- ☐ Personal care (such as bathing, dressing, toileting, etc.)
- ☐ Shopping and errands
- ☐ Supervision for safety
- ☐ Transportation
- ☐ Other

Please provide supporting documentation.

If Other, please explain

M.6 **Does the unpaid caregiver or other family have concerns about the individual's memory, thinking or ability to make decisions?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

IF M.6 IS YES ANSWER M.7

M.7 **Is the unpaid caregiver very concerned or somewhat concerned about the client?**

- ☐ Very concerned
- ☐ Somewhat concerned

M.8 **Are there any safety concerns that the unpaid caregiver has about this client or their home environment?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

M.9 **Given the client's CURRENT CONDITION, has the unpaid caregiver ever considered placing client in a different type of care setting, such as a nursing home or another care facility for long-term placement?**

- ☐ Probably not
- ☐ Definitely not
- ☐ Probably would
- ☐ Definitely would
- ☐ Does not apply – individual is in care facility

M.10 **How would you (the unpaid caregiver) describe your own health?**

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Chose not to answer

M.11 **Does the unpaid caregiver's health problems ever get in the way of providing care?**

☐ No ☐ Yes ☐ Chose not to answer

M.12 **How would the unpaid caregiver rate his/her level of stress related to caring for this individual?**

- ☐ None
- ☐ Low
- ☐ Medium
- ☐ High
- ☐ Unsure
- ☐ Chose not to answer

M.13 **Does the unpaid caregiver have difficulty getting a good night's sleep, 3 or more times a week as a result of caring for this client**?

- ☐ No
- ☐ Yes
- ☐ Sometimes
- ☐ Chose not to answer

M.14 **Is the care the unpaid caregiver provides impacting his/her ability to be employed as a result of caring for this client?**

- ☐ Working full time
- ☐ Yes, I can only work Part Time
- ☐ No I can't work at all
- ☐ N/A

M.15 **Does the unpaid caregiver have anyone to help with caregiving? This is unpaid assistance, not a provider**

☐ No ☐ Yes ☐ Chose not to answer

↓IF M.15 IS YES, ASK QUESTION M.16 BELOW: ↓

M.16 **Can the unpaid caregiver depend on this person to help when needed?**

- ☐ No
- ☐ Yes
- ☐ Unsure
- ☐ Chose not to answer

Please provide supporting documentation.

If No, please explain

M.17 **Is the unpaid caregiver currently receiving any caregiver support (e.g., respite, training or education, caregiver coaching or counseling or support groups)?**

☐ No ☐ Yes ☐ Chose not to answer

Please provide supporting documentation.

If Yes, please explain

M.18 **Are there any issues | obstacles that make it more difficult for the unpaid caregiver to provide support to the individual?**

☐ No ☐ Yes ☐ Chose not to answer

↓IF M.18 IS YES, CHECK ALL THAT APPLY: ↓

M.19 **Check all that apply:**

☐ Information
☐ Education or training (direct care skills, disease process)
☐ Help managing his | her memory care or behavior issues
☐ Help managing his | her care needs (medications, treatments)
☐ Help with finances
☐ Finding time for myself (respite, breaks from caregivers)
☐ One-to-one coaching or counseling
☐ Developing an informal network of support
☐ Dealing with family relationships and communications
☐ Home | Safety modifications
☐ Technology and assistive devices
☐ Hiring my own help
☐ Balancing work, family and caregiving responsibilities
☐ Help with chemical or mental health issues for myself
☐ Other

Please provide supporting documentation.

If Other, please explain

M.20 **On an average day, how many hours do you provide care for this individual PER DAY (If child, ask about variances in schedule for school vs non-school schedule.)**

☐ 0-4 hours of care
☐ 4.1 – 8 hours of care
☐ 8.1 – 16 hours of care
☐ 16.1 – 23 hours of care
☐ 24 hours of care

M.21 **On average, how many days per week do you provide care for this individual? Please consider times for work week vs weekend.**

☐ less than 2 days per week
☐ 3-4 days per week
☐ 5-6 days per week
☐ 7 days per week

M.22 **Please provide supporting documentation.**

Comments

N. Employment

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Employment: (Ages >= 13-64)

N.1 **Has your school team discussed plans to begin exploring your work, volunteer or post-secondary education options? (Ages 13-21)**

☐ No ☐ Yes ☐ Chose not to answer

↓IF N.1 IS NO, ASK N.2 BELOW: ↓

N.2 **Do you know referral to Vocational Rehabilitation is an option, even while they attend high school? (Ages 13-21)**

☐ No ☐ Yes ☐ Chose not to answer

N.3 **Describe planning efforts such as employment goals included on IEP, etc. (Ages 13-21)**

Comments

N.4 **Is the person currently employed? (Ages 13-64)**

☐ No ☐ Yes ☐ Chose not to answer ☐ N/A

↓IF N.4 IS NO, ASK N.5 BELOW↓
↓IF N.4 IS YES ASK N.6BELOW↓

N.5 **Which statement best describes your status at this time?**

☐ Unemployed: looking for work

☐ Unemployed: not looking for work - If unemployed and not looking for work, please explain:

☐ Retired

If unemployed and not looking for work, please provide supporting documentation

Comments

Type of Employment

N.6 **Type of employment:**

- ☐ Center-based sheltered employment | activity
- ☐ Competitive – with job support | coaching
- ☐ Competitive – without job support
- ☐ Educational Program
- ☐ Self-employed – with job support
- ☐ Self-employment – without job support
- ☐ Supported work in an enclave | group | crew setting
- ☐ Other

_____

Name of agency/contact

_____

If Other, please provide supporting documentation

O. Quality of Life

Return to Index

Routines and Preferences

O.1 **What is a typical day like for you?**

_____

O.2 **What are some things you enjoy doing?**

_____

O.3 **How do you want to spend your time?**

_____

O.4 **Do you like where you live?**

☐ No ☐ Yes ☐ Chose not to answer

If No, please explain

_____

Strengths and Accomplishments

O.5 **What are some of the things you feel you are good at doing?**

Notes/Comments

SUPPORTS, FAMILY, FRIENDS, AND OTHERS

O.6 **Who are some people you enjoy spending time with?**
Supports-Family, Friends and Others?

Future Plans

O.7 **What would you like for yourself in the future?**

Notes/Comments