CT DDS Level of Need Assessment and Screening Tool

Date: _____ Region: _____ Date of birth: _____

_____ ____ _____ _____

First name MI Last name DDS number

The answers on this form should reflect how much support or assistance the person needs or requires, *either for the management of a behavioral or health condition or to complete a task or activity. This may not be the same as how much support or assistance the person is currently receiving. Unless specifically asked to do otherwise, consider the past 3 to 6 months when answering the questions.* ***Please check only <u>one</u> box per item,*** *unless specifically asked to do otherwise. Include any explanations in the comments boxes.*

Health and Medical

Please check Yes for any prescribed medical treatments; check No if this treatment is not prescribed. Then insert codes for how often the treatment (or care for the treatment) is required, and who typically provides this care or support. Descriptions are given to better determine support frequency.

Support Frequency – How often care or assistance is typically needed for each treatment:

1 = Less than once a week
2 = Once a week
3 = Several times a week
4 = Once a day
5 = Multiple times a day
6 = Continuous

Support Provider – Who typically provides this support:

1 = RN
2 = LPN
3 = Respiratory therapist
4 = Physical therapist
5 = Occupational Therapist
6 = Unlicensed direct care staff
7 = Family member or friend
8 = Self

	At Home or Residence				At Day, School, Job, or Vocational Program			
Prescribed treatment or care	**Yes**	**No**	**Support Frequency**	**Support Provider**	**Yes**	**No**	**Support Frequency**	**Support Provider**
1. Catheter – If catheter is used continuously, consider catheter care only, such as insertion, removal, cleaning catheter, emptying bag.	☐	☐	____	____	☐	☐	____	____
2. Needle injection – Consider how often an injection is given.	☐	☐	____	____	☐	☐	____	____
3. Inhalation therapy or nebulizer – Consider how often each treatment is needed. This does not include oxygen.	☐	☐	____	____	☐	☐	____	____
4. Oxygen – If the oxygen is used continuously, consider how often care is needed to administer the oxygen; otherwise, consider how often oxygen is needed.	☐	☐	____	____	☐	☐	____	____
5. Respiratory suctioning – Consider how often respiratory suctioning is needed.	☐	☐	____	____	☐	☐	____	____
6. Postural drainage – Consider how often postural drainage is needed.	☐	☐	____	____	☐	☐	____	____
7. Ostomy (colostomy or ileostomy) – Consider care related to the ostomy, such as cleaning the tube area or emptying the bag.	☐	☐	____	____	☐	☐	____	____
8. Tracheostomy – Consider care of stoma, cannula, and any other trach care.	☐	☐	____	____	☐	☐	____	____
9. Tube feeding (nasogastric, G, or J tube) – Consider how often tube feeding required.	☐	☐	____	____	☐	☐	____	____
10. Artificial ventilator – This refers to mechanical ventilators which breathe for the person and are on continuously. Consider care and monitoring of ventilator.	☐	☐	____	____	☐	☐	____	____

11. If the family member as primary provider is not available for any of the above treatments, is this care then provided by a medically licensed support provider (for example, by an RN, LPN, respiratory therapist or physical therapist)?
    - ☐ No
    - ☐ Yes
    - ☐ Not applicable – Above care not provided by a family member or not needed

12. Does the person require any **hands on or direct care from a nurse** (LPN or RN) to provide routine care? This does not include routine examinations or assessments, such as blood pressure checks, incident monitoring, monthly assessments, etc.
- ☐ No → **If No, Skip to Question 14**
- ☐ Yes

13a. How often is this hands on or direct care from a nurse (RN or LPN) currently needed?
- ☐ 1 – 5 times a year
- ☐ 6 – 11 times a year
- ☐ Once a month
- ☐ 2 – 3 times a month
- ☐ Once a week
- ☐ 2 – 3 times a week
- ☐ 4 – 6 times a week
- ☐ At least once a day

13b. If daily hands on or direct care from an LPN/RN is needed, how much LPN/RN care is needed?
- ☐ Direct nursing care is not needed every day
- ☐ Less than 8 hours a day
- ☐ 8 to less than 16 hours a day
- ☐ 16 to less than 24 hours a day
- ☐ Continuous, 24 hour direct nursing care required
  If continuous nursing care needed, provide explanation in box at end of health section.

14. **In the past year**, how often did the person have a grand mal or convulsive seizure? Note: Other types of seizure activity are asked about in question 15.
- ☐ None in past year
- ☐ Less than once a month
- ☐ Once a month
- ☐ Several times a month or weekly
- ☐ Several times a week or more
- ☐ N/A – Has never had a seizure

15. **Check all the developmental disability diagnoses that apply:**
- ☐ Intellectual Disability
- ☐ Cerebral palsy
- ☐ Down Syndrome
- ☐ Prader Willi
- ☐ Other chromosomal disorder (Fragile X, Klinefelter's Syndrome, etc.)
- ☐ Autism, Asperger's Syndrome, or pervasive developmental disorder
- ☐ Brain injury (TBI, ABI)
- ☐ Spina bifida
- ☐ Fetal alcohol syndrome
- ☐ Other neurological impairment (includes meningitis, hydrocephalus, etc.)
- ☐ Other: _____

16. **Check all diagnosed health conditions:**
- ☐ No diagnosed health conditions
- ☐ Allergy – not life threatening
- ☐ Allergy – severe or life threatening
- ☐ Arthritis (osteoarthritis or rheumatoid arthritis)
- ☐ Asthma
- ☐ Auto immune disorder (rheumatoid arthritis, multiple sclerosis, lupus, etc.)
- ☐ Blindness – no functional eyesight
- ☐ Cancer
- ☐ Chronic constipation or diarrhea
- ☐ Deafness – no functional hearing
- ☐ Dementia or Alzheimer's disease
- ☐ Dental or gum disease
- ☐ Diabetes – oral medication required
- ☐ Diabetes – injected medication required
- ☐ Dysphagia (swallowing disorder)
- ☐ Eating disorder (anorexia or bulimia)
- ☐ Epilepsy or seizure disorder
- ☐ Foot or nail condition requiring podiatrist care
- ☐ GERD, acid reflux, or reflux esophagitis
- ☐ Heart condition
- ☐ Hepatitis
- ☐ High blood pressure or hypertension
- ☐ High cholesterol, hypercholesterolemia, or hyperlipidemia
- ☐ Kidney disease requiring dialysis
- ☐ Osteoporosis or osteopenia
- ☐ Parkinson's disease
- ☐ Pregnancy
- ☐ Pressure ulcer
- ☐ Pulmonary condition (emphysema, COPD, pulmonary edema)
- ☐ Severe scoliosis
- ☐ Sleep apnea
- ☐ Stroke or CVA
- ☐ Substance abuse – current
- ☐ Substance abuse – history of
- ☐ Hyperthyroid, hypothyroid, or thyroid disease
- ☐ Over weight
- ☐ Under weight
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

17. **Check all of the following which currently apply:**
- ☐ Requires food or liquid to be in particular consistency or size (for ex., chopped into specific pieces, ground up, pureed, thickened, etc.). Describe: _____
- ☐ Food consistency requirement change within past 3 months. Describe: _____

- ☐ Medically prescribed special diet (for ex., diabetic, low salt, high/low calorie, etc.). Describe: _____
  _____
- ☐ Unusual food preferences or food aversion. Describe: _____
- ☐ History or risk of dehydration
- ☐ History or risk of choking (swallowing risk factors include coughing during or after meals, excessive throat clearing during or after meals, or gagging on food or liquids)
- ☐ Currently smokes
- ☐ Two or more falls within past 3 months
- ☐ Hands on assistance or close supervision required to use stairs within his/her residence
- ☐ Tactile kinesthetic issues (for example, hypersensitivity to touch and other sensory stimulation such as light or sound)
- ☐ Medical devices (for ex., pacemaker, C-PAP machine, glucometer, seizure management device, prosthetic device, etc. Does not include glasses, contacts, or hearing aids). Describe:_____
- ☐ None of these apply

18. **Medical office visits, or off-site medical or mental health care**

Typical number of office visits person had in past year to see a licensed professional for medical or mental health care (such as a doctor; dentist; nurse; laboratory technician; physical, respiratory, or speech therapist; podiatrist; psychiatrist; psychologist; or behavioral therapist). This does not include in-home visits. Consider off-site medical or mental health office visits only (includes emergency room visits).

- ☐ None in past year
- ☐ 1 – 5 times a year
- ☐ 6 – 11 times a year
- ☐ 12 – 23 times a year
- ☐ 2 – 3 times a month
- ☐ Once a week
- ☐ 2 or more times a week

19. Please describe any problems with off-site medical appointments (for example, problems with getting to office):

_____

_____

20. **If person is currently hospitalized (medical or psychiatric) or in a rehabilitation facility:**
    a. Is a written discharge plan in place?
       - ☐ Yes
       - ☐ No
       - ☐ Person is not in a hospital/rehab facility
    b. Anticipated date of discharge: _____

21. **Please check all that apply regarding medications:**

- ☐ Medication/s require careful monitoring for side effects
- ☐ Heart medications or blood thinners (Lasix, Digoxin, Coumadin, etc.)
- ☐ Anti-seizure medications (Depokote, Dilantin, Valproic Acid, Phenobarbital, etc.)
- ☐ Concurrent use of two or more over-the-counter medications
- ☐ Frequent changes in medication
- ☐ Prescribed addictive medication (Codeine, Percocet, Vicodin, chloralhydrate, Oxycontin, etc.)
- ☐ Long-term use of a neuroleptic, psychotropic, mood or behavioral medication (Haldol, Klonopin, Ativan, Lithium, etc.)
- ☐ Frequently refuses to take prescribed medications
- ☐ Other medication risk (self-administration error, allergy to medication, etc.) – describe: _____
  _____
- ☐ None of these apply, or does not take any medications

Comments about health and medical:

Personal Care Activities

Please check the **one** box which best describes how much support the person **typically** requires to do each activity:

22. Dressing and undressing – includes ability to take clothes out of drawers, choose weather appropriate clothes, and use fasteners.
    - ☐ Dresses self independently. May use assistive devices, such as a reacher/extender, etc.
    - ☐ Able to get dressed, but needs prompting, or may need help with choosing weather appropriate clothing.
    - ☐ Requires hands on assistance with getting dressed.

23. Bathing or showering – includes sponge bath, tub bath or shower.
    - ☐ Draws bath and washes self independently, may use assistive devices, such as grab bars, bath brush, etc.
    - ☐ Able to bathe self, but may need help regulating water temperature or some type of prompting, monitoring, or encouragement. May need help washing back.
    - ☐ Requires hands on assistance to wash self and/or to get in and out of tub or shower.

24. Grooming and personal care – includes brushing teeth or hair, or shaving (electric or regular razor).
    - ☐ Grooms self and independently does own personal care. May use assistive devices.
    - ☐ Brushes teeth, shaves, and brushes hair, but needs some prompting or encouragement.
    - ☐ Requires hands on assistance to complete grooming activities.

25. Using the toilet – includes going to the bathroom for bowel and urine elimination, wiping self, menstruation care, diaper care, and ostomy/catheter care.
    - ☐ Uses toilet independently, may use assistive devices such as a raised toilet seat, etc.
    - ☐ Uses the toilet and wipes self with reminders, prompting, or encouragement.
    - ☐ Requires hands on assistance for toileting needs. May be incontinent. Includes those individuals using diapers, catheter, or ostomy.

26. Eating – includes ability to use fork or spoon from plate to mouth and to cut food. Does not include chewing or swallowing (covered in next question).
    - ☐ Eats independently. May use assistive devices.
    - ☐ Eats with reminders, prompting, or encouragement. May need assistance with cutting up food or prompting for pace.
    - ☐ Requires hands on assistance with putting food on utensil or requires hand over hand feeding.
    - ☐ Requires assistance for NG, G, or J tube feeding.

27. Chewing and swallowing – includes ability to chew food and swallow food without choking.
    - ☐ Chews and swallows independently.
    - ☐ Chews or swallows with monitoring, supervision, prompting or encouragement.
    - ☐ Cannot chew or swallow food or liquid.

28. Mobility in the home – includes the ability to move around inside the home or residence. How does this person usually get around inside the home?
    - ☐ Walks by self with or without assistive devices, such as a brace, walker, cane, prosthesis, etc.
    - ☐ Walks by self, but may require physical support or assistance from another person.
    - ☐ Does not walk. Uses wheelchair or scooter independently to get around.
    - ☐ Does not walk. Uses wheelchair with assistance from another person (such as to push wheelchair).

29. Transferring – includes ability to move from bed to a chair or to a wheelchair.
    - ☐ Moves in and out of bed or chair independently. May use assistive devices.
    - ☐ Moves in and out of bed or chair with monitoring, prompting, or encouragement.
    - ☐ Requires hands on assistance to transfer.

30. Changing position in bed or chair – includes ability to turn side to side. Does *not* include ability to get up out of bed or chair.
    - ☐ Changes position in bed/chair independently. May use assistive devices.
    - ☐ Changes position in bed/chair with some prompting or encouragement.
    - ☐ Requires hands on assistance to change position in bed/chair.

Comments about personal care activities:

Daily Living Activities

Please check the **one** box which best describes how much support the person **typically** requires to do each activity. Use best professional judgment and consult with others who know the person well if any uncertainty or if lack of opportunity to demonstrate. Write any comments in box following this section.

31. Mobility in the community – includes the ability to move around outside and in the community. *Does not include any transportation needs.*
    - ☐ Walks by self with or without assistive devices, such as a brace, walker, cane, prosthesis, etc.
    - ☐ Walks by self, but may require physical support or assistance from another person.
    - ☐ Does not walk. Uses wheelchair or scooter independently to get around.
    - ☐ Does not walk. Uses wheelchair with assistance from another person (such as to push wheelchair).

32. Taking medications – includes taking the correct medication and dose at the correct time or filling pillbox if used. Includes monitoring glucose level if needed.
    - ☐ Takes medications correctly by self (correct medication, correct dose, correct time). May use assistive devices such as a pillbox, etc.
    - ☐ Takes medications with monitoring, prompting, or reminders, or may need assistance to set up a weekly or daily pillbox.
    - ☐ Requires assistance to take medications, such as to prepare or administer the medication.
    - ☐ Does not take medications.

33. Using the telephone – includes dialing the number and/ or communicating over the phone.
    - ☐ Uses the telephone independently. May use assistive devices to dial or communicate over the phone (such as programmed dialing, TTY, etc.).
    - ☐ Uses telephone with prompting, instruction, or encouragement. May need assistance with dialing numbers.
    - ☐ Always requires assistance to use telephone or TTY, or cannot use telephone at all.

34. Doing household chores – includes housecleaning, laundry, etc.
    - ☐ Does household chores by self independently. May use assistive devices.
    - ☐ Does household chores with prompting, monitoring, instruction, or encouragement.
    - ☐ Requires assistance to complete household chores, or cannot complete household chores at all.

35. Shopping and meal planning – includes planning for meals and shopping for groceries or other goods in neighborhood area. *Does not include any transportation required.*
    - ☐ Plans for meals and shops for groceries, etc., in neighborhood stores independently. Excludes any transportation. May use assistive devices.
    - ☐ Plans for meals and shops in neighborhood stores with prompting, monitoring, or instruction. Excludes any transportation.
    - ☐ Requires assistance for meal planning and shopping, such as someone to make the grocery list or pay the cashier; or cannot do any part of shopping and meal planning at all. Excludes any transportation.

36. Meal preparation and cooking – includes getting the food out of the cupboard or refrigerator, preparing food (including making food into appropriate consistency such as ground up, specified piece size, pureed, or liquefied), making cold meals (such as sandwiches or snacks), and cooking simple meals.
    - ☐ Prepares and cooks food independently using either microwave or stove. May use assistive devices. Can make cold foods (sandwiches, snacks) or simple meals.
    - ☐ Prepares and cooks food such as sandwiches and simple meals with prompting, monitoring, or instruction. Can safely use a microwave with instructions, prompting, or monitoring.
    - ☐ Requires assistance to prepare and cook food. Cannot use either microwave or stove.

37. Budgeting and money management – includes being able to budget for expenses within a set income and pay bills.
    - ☐ Budgets, pays bills, and manages own money independently. May use assistive devices.
    - ☐ Budgets, pays bills, and manages money with prompting, monitoring, or instruction.
    - ☐ Requires assistance to budget, pay bills, or manage money, or cannot budget or manage money at all.

38. Transitioning – includes being able to discontinue one activity or task and begin another, including activities at home, school, work, vocational or day program, and leisure or recreational activities.
    - ☐ Transitions from or to activities or tasks by self independently.
    - ☐ Transitions to or from an activity with prompting, monitoring, instruction, or encouragement.
    - ☐ Requires assistance in order to transition from one activity to another.

Comments about daily living activities:

Behavioral and Mental Health

Please check Yes for any behaviors or diagnosed mental health conditions requiring monitoring or a treatment plan in the past year; otherwise, check No. Then fill in the codes for the type of support and level of support typically needed during waking hours for each behavior. Check all that apply. *If type of support required is a 3 or a 4, it is strongly suggested to include a description in behavior comments box on next page.* (Note: Overnight support is assessed in a later section of the form.)

Support Required –
Type of support typically required during waking hours:

0 = No support needed or can ignore behavior.
1 = Monitor only, using a person or through environmental means. Includes monitoring for behaviors controlled by medications or treatment plan.
2 = Verbal or gestural distraction or prompting typically needed.
3 = One person hands-on support typically needed to redirect or manage person.
4 = More than one person (2:1) typically needed to redirect or manage person. If so, please explain in behavior comments box.

Support Level –
Level of support typically needed to manage behavior during waking hours:

0 = No support required
1 = Less than monthly, episodic, or seasonal only
2 = One to 3 times a month
3 = Once a week
4 = Several times a week
5 = Once a day or more
6 = Continuous support during waking hours required for this behavior
7 = Person can never be left alone in a room and must always be in constant line of sight for behavioral support
8 = Person can never be left alone in a room and must always be within arms length for behavioral support

Behaviors in past year	At Home or Residence				At Day, School, Job, or Vocational Program			
	Yes	No	Support Type	Support Level	Yes	No	Support Type	Support Level
39. Opposes support or assistance Includes resisting care or assistance	☐	☐	____	____	☐	☐	____	____
40. Disruptive behaviors, not aggression Includes any behavior which disrupts or interferes with activities of the person or others.	☐	☐	____	____	☐	☐	____	____
41. Verbal aggression or emotional outbursts Includes verbal threats, name calling, verbal outbursts, and temper tantrums	☐	☐	____	____	☐	☐	____	____
42. Mild physical assault or aggression Does not cause injury, such as pushing, grabbing, or spitting	☐	☐	____	____	☐	☐	____	____
43. Severe physical assault or aggression Can cause injury such as biting, or punching, or attacking	☐	☐	____	____	☐	☐	____	____
44. Property destruction Includes the intentional destruction of property	☐	☐	____	____	☐	☐	____	____
45. Bolting Suddenly running or darting away (excludes wandering away)	☐	☐	____	____	☐	☐	____	____
46. Self-injurious behavior Includes any behavior which harms one's physical self, such as head banging, biting/ hitting self, skin picking, scratching self, etc.	☐	☐	____	____	☐	☐	____	____
47. Eating or drinking nonfood item (Pica) Includes ingestion of items or liquids not meant for food, such as paper clips, coins, detergent, dirt, cleaning solutions, etc.	☐	☐	____	____	☐	☐	____	____
48. Impulsive food or liquid ingestion Includes binge eating or compulsive, rapid ingestion of large quantities of food or edible liquids.	☐	☐	____	____	☐	☐	____	____
49. Wandering away Includes wandering away only	☐	☐	____	____	☐	☐	____	____
50. Sexually inappropriate behavior in past year Includes a wide range of behaviors such as disrobing, sexually inappropriate comments, masturbating in public, as well as sexually aggressive behavior	☐	☐	____	____	☐	☐	____	____
51. Criminal concerns in past year Includes any criminal justice issues or concerns, or problems with the law	☐	☐	____	____	☐	☐	____	____

For questions 52 – 54 please indicate the type of support and level of support required during waking hours using the Support Required and Support Level codes from page 6. Note that questions 52 – 54 ask about the history of certain behaviors or criminal concerns which happened more than one year ago.

History of sexual or physical assault or criminal behaviors (more than 1 year ago)	At Home or Residence: Yes	No	Support Type	Support Level	At Day, School, Job, or Vocational Program: Yes	No	Support Type	Support Level
52. History of sexual assault or sexual aggression towards others	☐	☐	____	____	☐	☐	____	____
53. History of severe physical assault	☐	☐	____	____	☐	☐	____	____
54. History of criminal concerns – Note below if currently on probation or parole	☐	☐	____	____	☐	☐	____	____
55. Is this person on the sex offender registry?	☐	☐						

Psychiatric or mental health condition

For questions 56 and 57, please indicate the type of support required during waking hours for any diagnosed psychiatric or mental health condition using the Support Required codes below. Then indicate the current status of the psychiatric or mental health condition for the past 3 to 6 months using the Current Status scale.

Psychiatric or Mental Health Condition Support Required –
Type of support typically required during waking hours:

0 = No support needed or can ignore behavior.
1 = Monitor only, using a person or through environmental means. Includes monitoring for behaviors controlled by medications or treatment plan.
2 = Verbal or gestural distraction or prompting typically needed.
3 = One person hands-on support typically needed to redirect or manage person.
4 = More than one person (2:1) typically needed to redirect or manage person. If so, please explain in behavior comments box.

Current status (past 3 – 6 months)

1 = Condition is well controlled or stable (includes controlled by medication or other means)
2 = Condition is intermittent or episodic
3 = Condition is uncontrolled or currently in crisis

Psychiatric or mental health condition (include formal diagnosis by mental health clinician)	At Home or Residence: Yes	No	Support Type	Current Status	At Day, School, Job, or Vocational Program: Yes	No	Support Type	Current Status
56. Diagnosed psychotic disorder – Includes schizophrenia, psychosis, schizoaffective disorder, etc. Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____
57a. Diagnosed mood disorder – Includes bipolar disorder, major depression, depressive disorder, etc. Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____
57b. Other diagnosed psychiatric or mental health condition – Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____

58. Does the person require a greater level of support due to behavioral or mental health concerns when out in the community?
☐ No
☐ Yes – *please describe in behavioral, mental, or emotional health comments box*

Comments about behavioral or mental health concerns?

Safety

		Yes	No	
59.	The person responds appropriately without prompting to basic safety issues at home – for example, evacuating the residence if there is a fire.	☐	☐	
60.	The person responds appropriately without prompting to other safety issues at home – for example, responding appropriately to lack of heat in winter or to a power outage.	☐	☐	
61.	The person is able to obtain necessary emergency assistance by some means – for example, dialing 911, pressing an emergency button, getting help from a neighbor, etc.	☐	☐	
62.	The person has auditory or visual disabilities that require adaptive or assistive devices necessary for safety (for example, tactile escape route, flashing fire alarm, or bed shaker).	☐	☐	
63.	The person requires use of bedrails while sleeping or while in bed.	☐	☐	
64.	The person experiences frequent absences or tardiness of his/her support staff or frequently has staff unfamiliar with his/her support needs.	☐	☐	
65.	Overall, the person usually makes safe choices when at home – for example, not putting metal in a microwave or toaster, not opening the door to strangers or locking the door at night.	☐	☐	
66.	Overall, the person usually makes safe choices when not at home – for example, crossing neighborhood streets safely or refusing a ride from a stranger.	☐	☐	
67.	The person responds appropriately to safety issues when not at home – for example, evacuating building appropriately if fire alarm goes off or staying on the sidewalk.	☐	☐	
68.	The person is in danger of accessing a body of water without supervision.	☐	☐	
69.	The person is able to avoid being taken advantage of financially – for example, not giving his/her money to strangers, or not giving out personal financial or social security information to strangers.	☐	☐	
70.	The person is able to avoid being taken advantage of sexually or is able to avoid sexual exploitation, including when at home, in the community, or with strangers.	☐	☐	
71.	The person uses the internet, cell phone, or other electronic communication or information devices appropriately. (Check not applicable if person does not have access to these devices.)	☐	☐	Not applicable ☐
72.	This person always requires 2 people for transferring, fire evacuation, or positioning.	☐	☐	
73.	The person's home is accessible to meet the individual's needs, including bathing facilities.	☐	☐	
74.	The person is at risk because of refusal of critical services.	☐	☐	
75.	The person is homeless now or is at risk of homelessness.	☐	☐	
76.	Are there any other safety concerns in the person's home or neighborhood that could put this person at risk? (**If Yes**, describe in safety comments box below.)	☐	☐	

77. Has the person experienced any of the following incidents in the past 12 months? Please check all that apply:

- ☐ Severe injury
- ☐ Emergency hospitalization
- ☐ Missing persons report
- ☐ Fire requiring emergency response or involving severe injury
- ☐ Victim of aggravated assault
- ☐ Victim of rape
- ☐ Substantiated abuse or neglect report
- ☐ Police arrest
- ☐ Vehicle accident with moderate or severe injury
- ☐ Emergency restraint
- ☐ Injury due to restraint
- ☐ Unusual incident or behavior not normally exhibited that was dangerous, illegal, or life threatening
- ☐ Suicide attempt or gesture
- ☐ Other (describe): _____
- ☐ None of the above

Comments about safety:

Waking hours level of support

Consider the support needs of the person for support, monitoring or assistance during waking hours only. (Overnight support is assessed later in the form.)

78. Does the person require any of the following during **waking hours**? This may include waking hours at his/her home or residence, day, school, job, or vocational program, or work. Check all that apply.
    - ☐ Door alarm
    - ☐ Chair alarm
    - ☐ Refrigerator alarm or lock
    - ☐ Other environmental monitoring or alarm (list): _____
    - ☐ None of the above

Day, School, Job, or Vocational Program Level of Support – Waking hours

79. What level of support, monitoring, or assistance is typically needed during employment, day, school, job, or vocational activities only (for those without services, indicate the predicted level of support)? Note: For school aged children, consider only Support Required the Entire Time.

    No support required:
    - ☐ Person is competitively employed or is independent during the day

    Periodic support required:
    - ☐ Job development and training only
    - ☐ Once a week or less
    - ☐ For part of each day or time period spent on employment, day, or vocational activities

    Support required for the entire time:
    - ☐ Larger group support (one staff person for 4 or more people)
    - ☐ Small group support (one staff person for 2 – 3 people)
    - ☐ One to one support due to personal support needs
    - ☐ More than one person support due to personal support needs

80. On average, how many total hours a week is the person involved in either day, school, job, or vocational program? _____ total hours per week

Home or Residence Level of Support – Waking Hours

81. Frequency of support, monitoring, or assistance – How often does this person typically need support during waking hours at his/her home or residence? Please check only one.
    - ☐ Less than monthly
    - ☐ 1 to 3 times a month
    - ☐ Once a week
    - ☐ Several times a week
    - ☐ Once a day
    - ☐ Multiple times a day
    - ☐ Continuous support needed during waking hours
    - ☐ Person can never be left alone in a room and must always be in constant line of sight
    - ☐ Person can never be left alone in a room and must always be within arms length
    - ☐ No support needed

82. Level of support, monitoring, or assistance – What level of support does this person typically need during waking hours at his/her home or residence? Please check only one.
    - ☐ On-call support only
    - ☐ Periodic in-person support
    - ☐ Lives in family home and needs support always available
    - ☐ Larger group support (one person for 4 or more people)
    - ☐ Small group support (one person for 2 – 3 people)
    - ☐ One to one support only, either at arms length or in constant line of sight
    - ☐ More than one person typically needed
    - ☐ No support is needed

83. During the day, how many hours at one time can this person typically be safely left alone in the house or residence at one time, with no other adults at home? _____ Hours

Overnight support, monitoring, or assistance

84. During overnight/sleep hours, how much support is typically needed for this person? Please check only one.
- ☐ No overnight support is needed
- ☐ Requires on-call support available during the night (someone available by phone)
- ☐ Requires a person in their residence who can be sleeping
- ☐ Requires a person to be awake throughout the night
- ☐ Requires a person to be awake and in either constant line of sight or at arms length throughout the night

85. Does the person require any of the following during overnight or when sleeping? Check all that apply.
- ☐ Bed alarm
- ☐ Vail or enclosed bed
- ☐ Door alarm
- ☐ Refrigerator lock or alarm
- ☐ Other environmental monitoring or alarm (list): _____
- ☐ None

Comments about support:

Comprehension and Understanding	**Yes**	**No**	
86. Can the person understand simple instructions or questions (for example, "Did you like your dinner?" or "Raise your arms")?	☐	☐	
87. Can the person understand complex instructions or questions with two different parts (for example, "Do you need eggs from the grocery store?" or "Please put on your coat, and take these letters to the mailbox")?	☐	☐	
88. If the person is age 18 or older, can the person read at the 5th grade level (for example, can the person read the local newspaper)?	☐	☐	☐ Is under age 18

Communication

89. Please check the one description which best describes the person's ability to communicate.
- ☐ Verbal communication with little or no difficulty, both expressing (sending) and receiving language.
- ☐ Verbal communication with some difficulty or limited skills with either expressing or receiving messages.
- ☐ Severely limited verbal (cannot easily form words), or is basically nonverbal. Usually uses alternative method of communicating such as manual or sign language, written words, pictures, electronic systems, communication board, gesturing or pointing, etc.
- ☐ Nonverbal with severe communication difficulties. Little or no expressive communication but may use some non-verbal communication skills such as eye gazing, or facial expressions. Does not use any alternative communication devices.
- ☐ Unable to communicate

90. Does the person follow social rules of conversation appropriately, in different situations and with different listeners? This includes taking turns when speaking, using appropriate language, and using an appropriate tone of voice.
- ☐ Always or most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Never

91. Does the person speak English? Please check one.
- ☐ Yes (or enough that no interpreter is needed)
- ☐ No – person needs a foreign language interpreter
- ☐ No – person needs an interpreter for the deaf
- ☐ Not applicable – person uses alternative communication system or cannot communicate

Comments about comprehension or communication:

Transportation

92. How does the person usually get to places out of walking distance? Check all that apply:
    - ☐ Uses a provider's van or vehicle
    - ☐ Gets ride from staff in staff person's car
    - ☐ Uses public transportation such as city bus
    - ☐ Gets a ride from a family member or friend
    - ☐ Uses para-transit, dial a ride, or handicapped van
    - ☐ Uses taxi service
    - ☐ Drives self
    - ☐ School bus
    - ☐ Other: _____

93. Does the person require a van with a lift?
    - ☐ Yes
    - ☐ No

94. Does the person require vehicle modifications to travel safely? This may include grab bars, seat belt extenders, or wheelchair tie downs.
    - ☐ Yes – please explain: _____
    - ☐ No

95. Does the person require support for his/her behaviors or for health reasons from other person(s) in addition to the driver while in a vehicle?
    - ☐ Yes – please explain: _____
    - ☐ No

96. How much support does this person require to arrange or schedule his/her own transportation? This may include looking up van or bus schedule, calling for ride, canceling ride if not needed, obtaining bus route or driving directions, or taking public transportation. Check only one box.
    - ☐ Able to arrange or schedule own transportation independently. This may include independently arranging for a van ride or using public transportation after initial instruction. Includes people who are able to drive. May use assistive devices, such as a phone amplifier, speed dialing, etc.
    - ☐ Able to arrange or schedule own transportation with prompting, monitoring, or instruction. May need help dialing phone or looking up bus/van schedule. Uses public transportation only with prompting or regular instruction.
    - ☐ Cannot arrange or schedule transportation at all.

Social Life, Recreation, and Community Activities

►► Answer the following 3 questions **without** thinking about transportation or mobility needs. Check one box for each.

97. Establishes and maintains friendships and supportive relationships – includes making friends and getting in touch with them, by either calling, emailing, in-person at events, work, etc. Excludes any transportation or mobility assistance needed.
    - ☐ Able to establish and maintain friendships independently. May use assistive devices.
    - ☐ Able to establish and maintain friendships only with prompting, encouragement, or social coaching.
    - ☐ Requires assistance to establish and maintain friendships, such as social training or help with dialing a number or signing up for an event.

98. Takes part in leisure activities, hobbies, or recreation in his/her home or residence – includes any leisure activities done at home, such as TV, music, reading, puzzles, etc. Excludes any mobility assistance needed.
    - ☐ Able to independently take part in leisure activities at home. May use assistive devices.
    - ☐ Able to take part in leisure activities at home only with encouragement, prompting, or monitoring. May need some initial assistance with getting a game out, putting in a video, etc.
    - ☐ Requires continual assistance to take part in leisure activities, hobbies, or recreation at home.

99. Takes part in activities in the community for recreation and enjoyment – includes movies, church, bowling, Special Olympics, dances, etc. Excludes any transportation or mobility assistance needed.
- ☐ Able to independently take part in activities in the community for recreation and enjoyment. May use assistive devices.
- ☐ Able to take part in activities in the community for recreation and enjoyment only with monitoring, prompting, or encouragement. May need some initial assistance with making plans, signing up for an event, etc.
- ☐ Requires continual assistance to take part in community activities for recreation and enjoyment.

100. How often does the person typically take part in activities in the community for recreation or enjoyment?
- ☐ Once a week or more
- ☐ Once or twice a month
- ☐ One to eleven times a year
- ☐ Never

101. What prevents the person from taking part in more activities in the community for recreation and enjoyment? Check **all** that apply.
- ☐ Low motivation or interest
- ☐ Behavioral or emotional concerns
- ☐ Social skills limitations
- ☐ Health concerns
- ☐ Money or cost concerns
- ☐ Inadequate transportation
- ☐ No one available to accompany the person
- ☐ Lack of available recreation activities
- ☐ Other: _____
- ☐ Nothing prevents person – He/she is happy with current amount of recreation activities

102. Does this person typically take part in educational opportunities in their community, such as adult education, night school, or community college?
- ☐ Yes, at least once a year
- ☐ Yes, but not in the past year
- ☐ No

Comments about transportation or social or community activities:

Person's Own Caregiving Responsibilities

103. Is this person a primary caregiver for another person?
- ☐ No
- ☐ Yes → What is his/her relationship to the person he/she is taking care of? _____

Person's Own Parental Responsibilities

This section concerns any parental responsibilities the person has themselves.

104. Does this person have any children?
- ☐ No → **If No, Skip to Question 106**
- ☐ Yes

105. Please check one box or fill in the blank for each one:

	Yes	No
a. Are any of this person's own children under age 18?	☐	☐
b. Is this person the primary caregiver for any of his/her children?	☐	☐
c. Does this person have legal custody of any of his/her children?	☐	☐
d. Is another agency involved in the care or protection of any of this person's children?	☐	☐
e. Is there a secondary caregiver for these children?	☐	☐
f. If there is a secondary caregiver, how is he/she related to the person? _____ ☐ There is no secondary caregiver		

Primary Caregiver Support (Unpaid)

Primary caregivers provide **unpaid**, direct care for the person and are usually responsible for the person's care. They are typically parents or close relatives with whom the person lives, or a CTH provider. This does not include CLA/group home staff.

106. Is this person his or her own primary caregiver?
- ☐ Yes → **Skip to Question 111**
- ☐ No

107. Does this person have an unpaid primary caregiver?
- ☐ No → **Skip to Question 111**
- ☐ Yes

108. How is the primary caregiver related to this person? Check only one.
- ☐ Person's spouse or unmarried partner
- ☐ Parent
- ☐ Sibling
- ☐ Grandparent
- ☐ CTH provider
- ☐ Other: _____

109. How is the secondary caregiver related to this person? Check only one.
- ☐ Person has no secondary caregiver
- ☐ Person's spouse or unmarried partner
- ☐ Parent
- ☐ Sibling
- ☐ Grandparent
- ☐ CTH provider
- ☐ Spouse or partner of primary caregiver
- ☐ Other: _____

110. Check the box in the first column if any of the following apply to the primary unpaid caregiver. Information may be obtained from the caregiver, other team or support staff members, or the person's record. Check any in the second column that apply to the secondary unpaid caregiver (such as when two caregiving parents). If no secondary caregiver, leave the second column blank. **Do not include any paid caregiving support.** Check all that apply.

	Unpaid Caregiver Profile	**Primary Caregiver**	**Secondary Caregiver**
a.	Caregiver is employed 20 hours a week or more	☐	☐
b.	Caregiver works during hours this person needs support	☐	☐
c.	Caregiver is age 65 - 74	☐	☐
d.	Caregiver is age 75 - 80	☐	☐
e.	Caregiver is age 81 or older	☐	☐
f.	Caregiver is also primary caregiver for aging parents, ill spouse, or other relative with disabilities	☐	☐
g.	Caregiver is also caring for an additional child or children who are under the age of 18 and who live with them	☐	☐
h.	Caregiver is frail or has poor health affecting ability to give care	☐	☐
i.	Caregiver cannot drive or has no car	☐	☐
j.	Caregiver limits driving to only around town or cannot drive at night	☐	☐
k.	Caregiver has memory problems affecting ability to give care	☐	☐
l.	Caregiver does not speak English	☐	☐
m.	Caregiver has a physical or mental health disability affecting ability to give care	☐	☐
n.	Caregiver has an intellectual disability affecting ability to give care	☐	☐

Other Unpaid Supports

111. Does the person have any other people who provide **unpaid** regular support or assistance at least once a month? This does not include anyone providing paid support or assistance. Check all that apply.
- ☐ Person has no regular, unpaid natural supports
- ☐ Parent or sibling
- ☐ Other family member: _____
- ☐ Friend
- ☐ Roommate
- ☐ Co-worker
- ☐ Neighbor/Member of his/her religious organization
- ☐ Unrelated guardian, conservator, or legal advocate
- ☐ Other: _____

Comments about unpaid caregiving supports:

Any other concerns

112. Include here any other concerns or considerations not captured elsewhere on this tool which impact this person's need for support:

Current Budget and Pending Service Requests

113a. Does the person currently have an individual budget?

☐ No
☐ Yes
☐ I don't know

113b. **If Yes, please indicate:** What is his/her current individual budget? $ _____

What is his/her current day budget? $ _____

What is his/her residential budget? $ _____

114. Does the person have a current service request pending with the Regional Planning and Resource Allocation team (PRAT)? (Waiting PRAT review or will be submitted with this assessment?)

☐ No
☐ Yes

Information about person(s) filling out this form

Name of person filling out form:	Relationship to the individual:	Work / Day Number:	Date completed:
_____	Case Manager	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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