Using the Navigation Pane allows quick and easy movement from one section or item to another within the tool.

To open the navigation pane, select ‘View’ at the top of the toolbar and check the box next to ‘Navigation Pane’ or use the hot keys of ‘Ctrl F’.

# ASSESSMENT & DEMOGRAPHIC INFORMATION

Name:       Preferred Gender:

Birthdate:       Age:       Prime#:

Phone:

Address/#:      

**Interview Date:**       **Face-to-Face Observation Date:**

**File Review Date:**       **Submit Date:**

Guardian name/#:

**Vision:** Select

**Hearing:** Select

**Service Setting:** Select

SC/PA:      County:

|  |
| --- |
| Additional comments related to case management entity: Click or tap here to enter text. |

**Did the individual participate in the assessment?**  Yes  No

|  |
| --- |
| Type of involvement or why individual was not able to participate: Click or tap here to enter text. |

**People who attended and/or contributed:**

Name:       Phone:       Email:

Lives with Individual:  Yes  No

Relationship: Select Participation level: Select

Name:       Phone:       Email:

Lives with Individual:  Yes  No

Relationship: Select Participation level: Select

Name:       Phone:       Email:

Lives with Individual:  Yes  No

Relationship: Select Participation level: Select

Name:       Phone:       Email:

Lives with Individual:  Yes  No

Relationship: Select Participation level: Select

# COMMUNICATION

## 1(a) How does the individual Communicate w/others?

Verbal English

Verbal Spanish

Verbal other language, specify:

Sign language

Writing/Braille

Gestures

Facial expression

Communication board

Electronic device

Texting/email/social media

Other:

## 1(b) How do others Communicate w/the individual?

Verbal English

Verbal Spanish

Verbal other language, specify:

Sign language

Writing/Braille

Gestures

Facial expression

Communication board

Electronic device

Texting/email/social media

Other:

|  |
| --- |
| **1(c)** Identify any other communication preferences or needs. Include issues with communication with reference to setting: Click or tap here to enter text. |

|  |
| --- |
| #1 Notes: Click or tap here to enter text. |

## 2(a) **Clarity of speech (words not messages):** Select

## **2(b) Expression (verbal and non-verbal) of ideas w/familiar people:** Select

## **2(c) Expression (verbal and non-verbal) of ideas w/unfamiliar people:** Select

## 2(d) Ask for/get Drink or indicate thirst – enough to avoid dehydration:

Yes  No, describe why unable:

## **2(e) Understanding verbal content:** Select

|  |
| --- |
| #2 Notes: Click or tap here to enter text. |

# ACTIVITIES OF DAILY LIVING (ADLs)

## 3. Dressing-skip under 4yo:

**(a)** Upper body: Select

**(b)** Lower body: Select

**(c)** Footwear: Select

**(d)** Preferences:

Female support person  Male support person

Changes clothes multiple times daily

Choose own clothes

Same clothing daily

Wears loose clothing

Velcro closures

Other

**(e)** Guidance:

Able to direct support person

Behavioral health challenges

Can button clothing

Can lift arms

Medical/physical symptoms interfere with performing task

PPS dress individual’s lower body

PPS individual’s upper body

Gets dressed with cueing

PPS help select appropriate, clean, and/or matching clothes

PPS label/organize clothing by color, style, etc.

Able to manage his/her own need

PPS put on/take off footwear

PPS put on/take off sock/TED hose

2-person assist

Able to tie

Able to zip

Will attempt to wear dirty clothes

Other

|  |
| --- |
| #3 Notes: Click or tap here to enter text. |

## 4. Transfer/Position-skip under 3yo:

**(a)** Sit Stand (only): Select

**(b)** Chair/Bed Chair, etc. transfers, standing up & sitting down/lying down: Select

**(c)** Roll left and right (including assistance for changing incontinence garments or similar): Select

**(d)** Preferences:

PPS use a gait belt

Someone to assist

Mechanical/ceiling lifts

transfer board/pole

Weight bearing trans

Other

**(e)** Guidance:

Asks for assistance

Behavioral health challenges

PPS assist with all wheelchair transfers

Can transfer self-using a lift

PPS cue to use adaptive equipment

Medical/physical symptoms interfere with performing task

Has good upper body strength

PPS maintain contact until steady

Individual able to manage his/her own need

Regular repositioning required

PPS should talk individual through each transfer

Transfer quickly  Transfer slowly

Transfers with some support

2-person transfer

Steady during transfer

Use mechanical lift for ALL transfers

Other

|  |
| --- |
| #4 Notes: Click or tap here to enter text. |

## 5. Mobility

**(a)** Does Ind Walk, scoot, crawl, shimmy, etc.**-skip under 3yo**: Select

**(b)** Walk, scoot, crawl, etc. **-skip under 3yo**: Select

**(c)** On/off curb/1 step**-skip under 3yo**: Select

**(d)** Up/Down steps**-skip under 3yo**: Select

**(e)** Wheelchair/Scooter used**-skip under 3yo**: Select If wheelchair is used, indicate type: Select

**(f)** Wheels **-skip under 3yo**: Select

**(g)** 2+ falls in past year:  Yes  No  Unknown

**(h)** Falls causing major injury with ongoing impact on ability to function:  Yes  No  Unknown

If yes, indicate type of injury and description of ongoing impact:  Fracture  Head Injury  Other (describe):

**(i)** Preferences:

Can walk, but prefers wheelchair

Cane

Crutch

Contact guard when walking

Electric wheelchair

manual wheelchair

pushed in wheelchair

walker

Walker with fold-down seat Walker with permanent seat

Gait belt

Other:

**(j)** Guidance:

Access to backup equipment or same day repair is necessary

Individual is afraid of falling

PPS should assist individual over thresholds

Can self-propel wheelchair

Behavioral health challenges

Medical/physical symptoms interfere with performing task

Evacuation plan: call neighbor or friend

Evacuation plan: support person assistance

Evacuation plan: use personal emergency response system (PERS)

Has a steady gait

PPS keep walkways clear

Individual leans to one side

PPS leave assistive device within reach

Individual able to manage his/her own need

Good navigation

PPS provide contact guard when walking

PPS provide physical support with stairs

PPS remind individual to use assistive device

Batteries recharged daily by support person

Sees well enough to navigate independently

Two-person assist

Able to exit in emergency

Able to walk/bear weight

PPS hold the gait belt to steady the individual

Other:

|  |
| --- |
| #5 Notes: Click or tap here to enter text. |

## 6. Eating/Tube Feeding:

**(a)** Nutritional Approaches**:** Select

**(b)** Eating**-skip under 4yo**: Select

**(c)** Tube Feeding: Select

**(d)** Preferences:

Bland diet

Use own recipes

Cold food  Hot food

Eat/tube feed alone Eat/tube feed with others present

Snacks

Finger foods

Large portions  Small portions

Support person to inject formula slowly

Tube feeding to be done discretely

Environmental preferences – likes to be warm, watch TV, etc.

Other

**(e)** Guidance:

Behavioral health challenges

Can cut food

PPS cut food into small pieces

Medical/physical symptoms

Has a good appetite

Independent with equipment/adaptations

Food allergies

PPS monitor liquids

Mouth pain

PPS provide cues for eating

Uses tube feeding pump

Uses gravity method Uses syringe method

Strategic timing of tube feeding

Must stop and start tube feeding process frequently - tube clogs easily, person gets up frequently, etc.

Two-person assist

Other:

**(f)** Does the individual have any signs or symptoms of a possible swallowing disorder?  Yes  No

(If yes; check all that apply)

Pain with swallowing

Coughing/choking while eating

Holding food in mouth/cheeks

Loss of liquids/solids from mouth

NPO

Other:

**(g)** Does Individual refuse foods due to preferences or sensory issues, such as texture or taste to point of malnutrition/dehydration:  Yes  No If Yes, describe:

**(h)** Does the ind. drool excessively:  Yes  No

**(i)** Does the Individual complain of chest pain, heartburn, or have small, frequent vomiting or unusual burping:  Yes  No

**(j)** Has the Individual required intravenous (I/V) fluids due to dehydration in the last year:  Yes  No

|  |
| --- |
| #6 Notes: Click or tap here to enter text. |

## 7. Elimination:

**(a)** Elimination hygiene (do not include washing hands)**-skip under 4yo**: Select

**(b)** Toilet transfer**-skip under 4yo**: Select

**(c)** Preferences:

Adult protection/absorbent products

Diapers

Bedpan only

Bedside commode

Female SP  Male SP

Pads/briefs when going out

Specific products

Urinal

Other

**(d)** Guidance:

Able to use incontinence products

Assists support person with transfer

Aware of need to use toilet

Behavioral health challenges

PPS provide assistance finding the bathroom

Able to change incontinence pads

Able to complete own perineal care

Able to empty ostomy/catheter bag

Does not need assistance at night

Experiences urgency

Painful urination

Will use pads/briefs

2-person assist

Condom catheter used with support person assist

Pads changed by support person, as needed

Medical/physical symptoms interfere with performing task

Other

**(e)** Has the person experienced Issues around *constipation in last year*:  Yes  No

(mark yes if any of the items f through I are Yes)

**(f*)*** *Routine/PRN* medications for constipation 2 or more x’s/month in last yr. (not fiber):  Yes  No

**(g)** Does Ind. have *diagnosis* of chronic constipation or *ongoing issues* w/ constipation:  Yes  No

**(h)** Required a suppository or enema in past year:  Yes  No

**(i)** Digital impaction removal 5 or more days/week:  Yes  No

**(j)** More than 1 painful bowel movement in past year:  Yes  No

**(k)** More than 1 episode of hard stool in past year:  Yes  No

**(l)** Takes meds causing constipation and wouldn’t recognize/communicate if constipated:  Yes  No

|  |
| --- |
| #7 Notes: Click or tap here to enter text. |

## 8. Showering and Bathing-skip under 5yo:

**(a)** Shower/bathe self (include transfer): Select

**(b)** Preferences:

Bath  Shower

Bed bath  Sponge bath

Male support person Female support person

Specific products

Other

**(c)** Guidance:

Able to direct PPS

Able to manage own need

Afraid of bathing  Enjoys bathing

PPS assist with drying and dressing

Bathes w/cueing

Behavioral health challenges

Can be left unattended  Standby during bathing

Can judge water temperature

Can adjust water temperature

Medical/physical symptoms interfere with performing task

Individual is weight bearing

Skin checks are completed by support person

PPS soak the individuals’ feet

2-person assist

Able to transfer in/out of tub/shower

Able to shampoo

Able to stand alone

PPS wash the individuals back, legs, feet

Other

|  |
| --- |
| #8 Notes: Click or tap here to enter text. |

## 9. Oral Hygiene-skip under 5yo:

**(a)** Oral Hygiene: Select

**(b)** Preferences:

Assistance after eating

Assistance during morning routine

Assistance before bedtime

Female SP  Male SP

Electric toothbrush

Other

**(c)** Guidance:

Able to manage his/her own need

PPS cue to brush teeth

PPS assist to clean teeth/dentures

Medical/physical symptoms

Aware of hygiene needs

Behavioral health challenges

Other

|  |
| --- |
| #9 Notes: Click or tap here to enter text. |

## 10. General Hygiene-skip under 5yo:

**(a)** General Hygiene (focus coding on daily hygiene tasks): Select

**(b)** Preferences:

Assistance after eating

Electric razor

Assistance during morning routine

Assistance before bedtime

Female SP  Male SP

Other

**(c)** Guidance:

Able to manage his/her own need

PPS applies the individuals’ deodorant

PPS combs the individuals’ hair as needed

Able to comb hair

Able to wash face/hands

Medical/physical symptoms interfere with performing task

Needs reminders to use/change feminine hygiene products

Individual knows how to use feminine hygiene products

PPS shave the individual daily or as needed

PPS trim the individual’s fingernails as needed

Aware of hygiene needs

Behavioral health challenges

Other

|  |
| --- |
| #10 Notes: Click or tap here to enter text. |

**Support Person assists**

## **11. ADL Equipment** Current Usage with equipment Comments

|  |  |  |  |
| --- | --- | --- | --- |
| Mechanical lift | Select |  |  |
| Prone Stander | Select |  |  |
| Sidelyer | Select |  |  |
| Body Jacket | Select |  |  |

|  |
| --- |
| #11 Notes: Click or tap here to enter text. |

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

## 12. Housework- skip under 12yo:

**(a)** **Housework:** Select

(Consider all housekeeping tasks required to maintain a clean home environment not just the tasks the individual currently engages in)

**(b)** Preferences:

Likes a neat house

Wants items left where they are

Prefers others to complete

Other:

**(c)** Guidance:

Able to sweep

Allergies to dust, pollen, etc.

Behavioral health challenges

Individual can do dishes

Individual can instruct support person

Individual can take out garbage

Individual can wash windows

Individual can make or change bedding

Individual can see when surfaces need cleaning

PPS change/wash linens weekly

PPS cue the individual to perform tasks

Medical/physical symptoms interfere with performing tasks

PPS dust/vacuum as needed

Individual has chemical sensitivities

PPS take out garbage

PPS sweep/mop floors

Other:

|  |
| --- |
| #12 Notes: Click or tap here to enter text. |

## 13. Meal Preparation- skip under 12yo:

**(a)** Make all the meals individual consumes: Select

**(b)** Preferences:

Bland diet

Casein free diet

Foods from my culture

Fresh fruits and vegetables

Gluten free diet

Halal diet

Home-cooked meals

Home delivered meals

Kosher diet

Smaller meals, more than three times per day

Large portions Small portions

Other religious/ethnic foods

Salt-free foods

Sugar free foods

Vegetarian diet

Vegan diet

Other therapeutic diet:

Other:

**(c)** Guidance:

Individual assists with meal preparation

Behavioral health challenges

Individual can prepare food with cueing

Individual can use the microwave

Individual can cut/peel/chop

Individual can plan meals

Individual directs PPS to prepare meal

Individual needs assistance when using kitchen

Medical/physical symptoms interfere with performing task

Individual knows how to cook

Individual has food allergies

Individual has accessible kitchen

Individual keeps spoiled food

PPS label/organize food products

Individual leaves burners on

Individual makes appropriate meal choices

PPS make food accessible to the individual

PPS prepare all meals

PPS prepare meals for individual to reheat

Individual has special diet

Work out a menu with individual

Other:

|  |
| --- |
| #13 Notes: Click or tap here to enter text. |

## 14. Laundry- skip under 12yo:

**(a)** Laundry:Select

**(b)** Preferences:

Prefers to fold certain items, describe:

Prefers others to complete

Wants items left where they are

Other:

**(c)** Guidance:

Individual has allergies to certain detergents or soaps

Behavioral health challenges

Individual can fold clothes

Individual can instruct support person

Individual can operate washer/dryer

PPS cue the individual to perform tasks

Medical/physical symptoms interfere

|  |
| --- |
| #14 Notes: Click or tap here to enter text. |

## 15. Transportation:

**(a)** Use vehicle Transportation including transfer- skip under 12yo: Select

(Unless b is coded Dependent, a can not be coded Dependent)

**(b)** Car transfer only- **skip under 3yo**: Select

**(c)** Preferences:

Accessible Bus

Bike

Taxi

Ride sharing (e.g., Uber)

Use own car, individual drives

Use own car, other person drives

Other:

**(d)** Guidance:

PPS accompany person on bus/van

PPS arrange medical transportation

Behavioral health challenges

Individual able to communicate with drivers

PPS use own car

PPS drive to appointments

Has handicap parking sticker/license

Knows bus routes

PPS make arrangements for accessible bus

PPS take portable oxygen tank

PPS take wheelchair/walker

PPS assist with securing wheelchair in accessible vehicle

Medical/physical symptoms

Individual needs orientation and mobility training for new routes

Individual able to arrange own transportation

PPS use supportive seating

Support person assists the individual to use vest/harness

Other:

|  |
| --- |
| #15 Notes: Click or tap here to enter text. |

## 16. Money Management- skip under 12yo:

**(a)** Money Management:Select

**(c)** Guidance:

Able to budget

PPS arrange credit counseling

Support person balances individuals’ checkbook

Behavioral health challenges

Can use EBT card

Can use debit card

Can write checks and pay bills

Can see/read bills and account information

PPS contact POA regarding finances/issues

PPS contacts rep payee regarding financial issues

Individual signs own checks

Med/physical symptoms interfere with performing tasks

Has a rep payee

Has direct deposit

Has guardian/POA

Needs POA

Support person pays bills for the individual

Needs automatic payment plan set up

Needs assistive/adaptive equipment to see paperwork

Needs budget set up

Needs utility pay set up

Vulnerable to financial exploitation

Relies on others to understand that money has value

Other:

|  |
| --- |
| #16 Notes: Click or tap here to enter text. |

## 17. Shopping- skip under 12yo:

**(a)** Shopping for all groceries and personal items the individual requires/consumes: Select

**(b)** Preferences:

Shop at a specific store

Shop weekly

Specialty items

Use coupons

Other:

**(c)** Guidance:

Able to communicate with store personnel

PPS arrange to have groceries delivered

Behavioral health challenges

Can carry small items

Can navigate within the store

Can see/identify needed items

Can carry heavy items

Can reach items

Can read labels

Can shop online

Medical/physical symptoms interfere with performing task

PPS assists with comparison shopping

PPS do all shopping for the individual

Support person guides individual within store, find/describe items

PPS help individual make shopping list

PPS read labels to the individual

PPS put items away

PPS take the individual to store

Other:

|  |
| --- |
| #17 Notes: Click or tap here to enter text. |

# BEHAVIORS

*\*The Code ‘Yes, Present…’ is used if behaviors* ***AND/OR*** *preventions have been in place in the past year.*

## 18. Injurious to self: Select

**Presenting behaviors:** (Only check presenting behaviors when present/prevented in past year)

Chemical abuse

Cutting self

Head banging

Suicide attempts

Fascination with fire

Pulling out hair

Self-biting

Self-burning

Self-hitting

Self-stabbing

Self-picking

Self-restrict eating

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 19. Aggressive or Combative: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Bites

Hits/punches

Kicks

Pulls other’s hair

Pushes

Scratches

Throws objects at others

Unwanted touching

Tripping

Uses objects to hurt others

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 20. Injurious to Animals: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Rough pulling on limbs

Attempts to main or kill

Sexual abuse against animals

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 21. Verbal Aggression towards Others: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Aggressive gestures with no physical contact

Goads

Intimidates/stares

Manipulates

Resists care

Swears at others

Taunts/teases

Verbal threats

Writes threatening notes

Yells/screams

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 22. Socially Unacceptable (Isolating) Behavior: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Disrupts others activities

Does not understand personal boundaries

Spits

Throws food

Voids in inappropriate places

Vocalizes loudly – not aggressive

Exposes private body areas

Inappropriately touches others

Masturbates in public areas

Unwanted touching of others

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 23. Sexual Aggression/Assault (lead to legal issues): Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Gropes others

Unwanted touching of others

Forcible attempts to engage others in sexual acts

Pedophilia

Targets vulnerable population

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 24. Property Destruction: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Breaks things

Punches holes in the walls

Sets fires

Uses tools/objects to damage property

Targets other’s property

Breaks small objects

Cuts cords

Tears clothing

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 25. Leaving Supervised Area: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Wanders away from support person while in the community

Leaves for extended period of time without informing the appropriate person

Runs away

Attempts to jump out of vehicle

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 26. Pica/put inedible in mouth with risk: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Dirt

Glass

Stones

Paper

Hair

Urine

Feces

Wood

Toxic substances (e.g., soap, cleaning solutions)

Cigarettes

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 27. Difficulties Regulating Emotions: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Cries uncontrollably

Frequently argues about small things

Impulsivity

Overly excitable

Screams

Shouts angrily

Overzealous social exchanges

Refuses to move (plants self)

Self-injury

Throws self on floor

Uses inappropriate tone for conversation

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 28. Refusing ADL/IADL and Medical Care: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Is physically combative against assistance

Is verbally combative against assistance

Is resistant against specific ADL/AIDL assistance, describe in 28b

Is resistant to being seen by a medical professional

Is resistant to taking medications

Requires full sedation for medical appointments

Requires full sedation for dental appointments

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 29. Rapid Ingestion of Foods/Liquids w/health and safety risk: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Rapid ingestion of liquids

Rapid ingestion of foods

Behavior only present with specific foods/liquids, describe in 29b

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 30. Withdrawal that impacts functioning, health, and/or safety: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Avoidance

Isolation

Lack of interest in life events

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 31. Intrusiveness: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Inappropriate boundaries

Physical

Verbal

Inappropriate eye contact (e.g., extended periods of time)

Unaware of interpersonal space

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 32. Behaviors that increase victimization risk: Select

(code general susceptibility to victimization due to judgment in item 40a)

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Hitchhiking

Inviting strangers into their home

Panhandling

Promiscuity

Puts self in harm’s way

Shares personal identifying information

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 33. Legal Involvement due to criminal behavior: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Assault

Burglary

Commits arson

Issues related to houselessness (e.g., urinating in public, camping ban violations, etc.)

Drug related crimes

Financial crimes

Prostitution

Public nuisance

Sexual crimes

Shoplifting

Terroristic threats

Theft

Trespassing

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 34. Other Behavior: Select

Presenting behaviors: (Only check presenting behaviors when present/prevented in past year)

Fecal smearing

Hoarding

False reporting (with intent of getting someone in trouble)

Calls 911 inappropriately

Problem gambling

Other (describe in b)

|  |
| --- |
| **(b)** Description of behaviors and/or any potential concern: Click or tap here to enter text. |

|  |
| --- |
| **(c)** Description of intermittent/cyclical behaviors, if applicable: Click or tap here to enter text. |

|  |
| --- |
| Notes: Click or tap here to enter text. |

## 36. Intervention frequency:

**(a)** Cueing (including physical gestures, unscripted, **proactive** & reactive cues/language): Select

**(b)** Proactive Strategies/Physical Prompts (including scripted language, deflection/evasion): Select

**(c)** Safeguarding interventions written into a PBSP (AKA PPIs): Select

|  |
| --- |
| #36 Notes: Click or tap here to enter text. |

## 37. Other behavior items:

**(a)** Is a court mandated restriction currently in place against theindividual (includes SO registration, probation, parole, restraining order, etc.):  Y  N

Type/Reason/Order date:

**(b)** Does the individual have a current court mandated restriction in place against anyone:  Y  N

Type/Reason/Order date:

|  |
| --- |
| #37 Notes: Click or tap here to enter text. |

## 38. Substance Abuse Issues:

**(a)** Is there a concern about abuse of substances, including alcohol, marijuana, prescription medication, or illegal drugs:  Yes  No

Type and use of substance:

|  |
| --- |
| #38 Notes: Click or tap here to enter text. |

## 39. Positive Behavior Support Plan:

**(a)** Has a PBSP been created for the individual:  Y  N

**(b)** Is the PBSP currently implemented by PPS:  Y  N

(to code Yes, the plan must be reviewed annually by the ISP team and/or behavior specialist, and used by paid/unpaid support people.)

**(c)** Does PBSP require doc incidence of behaviors:  Y  N

**(d)** Does the PBSP include SI/PPIs:  Y  N

**(e)** Does the PBSP include complex behavior support tools that must be altered by a support person one or more times per month:  Y  N

**(f)** Has the individual required emergency, crisis intervention, protective or restraints (not approved SI’s in PBSP) services to address a dangerous behavior 2 or more times in the past 12 months:  Y  N

|  |
| --- |
| #39 Notes: Click or tap here to enter text. |

# SAFETY

## 40. Safety Awareness and Support- skip under 5 yo:

**(a)** Does the individual have the judgment and/or physical ability to cope, make appropriate decisions, and take action in a changing environment or a potentially harmful situation (general personal safety awareness and protection): Consider **ALL** risks related to health and safety that are specific to the individual.

Yes

No, check all that apply and describe below

Judgement/Decision making:

Physical Ability (limitations related to CP, injury, etc.):

Behavior Issue (individual’s behavior hinders safety to exacerbates risk):

**(b)** Does the ind. need support to remain safe around traffic:  Yes, describe  No

|  |
| --- |
| Traffic Notes: Click or tap here to enter text. |

**(c)** Does the ind. need support to evacuate when a fire or smoke alarm sounds:  Yes, describe  No

|  |
| --- |
| **Evacuation notes:** Click or tap here to enter text. |

|  |
| --- |
| #40 Notes: Click or tap here to enter text. |

## 41. Environmental Safety:

**(a)** Is the individual at risk of serious injury from household chemicals IF the chemicals are not secured:

No  Yes, describe:

**(b)** Are there currently conditions in the residence that may lead to injury or illness:

(e.g. construction, broken windows, black mold, or similar)

No  Yes, describe:

**(c)** Is the individual at risk of eviction/lose housing because of conditions in residence/other:

No  Yes, describe:

|  |
| --- |
| #41 Notes: Click or tap here to enter text. |

## 42. Assessor’s Judgement about the Potential for Abuse, Neglect, and Exploitation:

**(a)** Evidence of historic or current abuse, neglect, or exploitation:

No

Yes, describe reasons:

**(b)** Evidence of historic or current self-neglect - **skip under 18yo**:

No

Yes, 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 judgement

Inability to manage funds that may result in negative consequences

Inability to manage medications or seek medical treatment that may threaten health or safety

Unsafe/unhealthy living conditions

Other:

**(c)** Has child welfare been involved on behalf of the individual-**skip over 17yo**:  Yes  No

|  |
| --- |
| #42 Notes: Click or tap here to enter text. |

# MEDICAL

## 43. General Medical Supports:

**(a)** In the past 6 months, how many times has another person recommended that the individual seek medical attention for an issue that the individual was unaware of or unwilling to seek attention for- **skip under 18yo:**  Select

**Select the reason(s) individual did not seek attention for medical issue:**

Individual unaware of issue(s)

Individual unwilling to seek attention for issue(s)

Other:

**(b)** Does the individual currently experience a lack of access to medical care because of transportation, geographical, financial, cultural, or other non-behavioral reasons:

Yes, select and describe

(Check all that apply)

Transportation

Geographical

Financial

Cultural

Other:

No

(c) Does the individual require documented daily monitoring of – ALL 4 – temperature, respiration, heart rate, and/or blood pressure according to a documented physician’s order:

Yes

No

**(d)** Is the individual able to report or describe pain and /or signs of illness and where it’s located:

Yes

No, describe:

**(e)** Does the individual need assistance to make and/or keep medical appointments**- skip under 18yo**:

Yes, describe:

No

|  |
| --- |
| #43 Notes: Click or tap here to enter text. |

## 44. Conditions and Diagnoses:

Health conditions/Specific Diagnoses:

**Has Affects Receiving Needs Follow up**

**Condition Functioning Treatment or Referral**

**(a)** Chronic Chest Congestion:

**(b)** Dysphagia:

**(c)** GERD:

**(d)** Persistent cough:

**(e)** Pneumonia (in last year):

**(f)** Rattling when breathing:

#44 Notes: Click or tap here to enter text.

## 45. **Seizure & Diabetes**

**(a)** Does the individual have a diagnosis of seizures or epilepsy or has the individual had a seizure within the past five (5) years:  Yes  No

**(b) In**dicate all items that apply to the individual:

Currently takes medication to control seizures

Required a PRN medication (such as Ativan or Diastat) **two or more times/month**, at the time of the seizure **to stop** seizure in the past year

Has taken medication to control seizures in the past year

Has had a seizure in the past year

Has had seizures that required emergency medical attention in the last three years

Uses a vagus nerve stimulator (**VNS**) two or more times/month

**(c)** Does the individual require support to prevent injury during or prior to a seizure episode:

Yes, describe support needed:

No

**(d)** Does the individual have a diagnosis of diabetes or pre-diabetes?

Yes, diabetes Yes, pre-diabetes  No

**(e)** Does the individual use a diabetic insulin pump:  Yes  No

**(f)** Does the individual’s diabetes management include administration of sliding scale insulin?

Yes, Administered by the individual without in-person assistance

Yes, Administered by the individual with in-person assistance

Yes, Administered by support person

No

**(g) Mechanisms used to manage diabetes:**

**Currently used Additional support needed to use Chooses not to use**

|  |  |  |  |
| --- | --- | --- | --- |
| Therapeutic Diet |  |  |  |
| Exercise |  |  |  |
| Blood Glucose Testing |  |  |  |
| Insulin Administration |  |  |  |
| Other: |  |  |  |

#45 Notes: Click or tap here to enter text.

## 46. Treatments and Therapies:

**(a)** Is the individual currently receiving or currently needs any special treatments, such as pacemaker, bowel program, ostomy care, oxygen therapy, feeding tube, or dialysis:  Yes  No

*\*Include Treatments and Monitoring the individual has had in the past if the ISP team so chooses.*

**(b) Treatments and Monitoring:**

**Column 1:** Treatment / Therapy

**Column 2:** (SPP) Check if the Support Person Performs the treatment

**Column 3:** (RT) Check if the Support Person requires regular training and oversight from a medical professional (such as nursing delegated tasks)

**(b) Treatment/Monitoring/Therapy Current Need SPP RT Notes/comments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Respiratory therapy | Select |  |  |  |
| Chest percussion (include percussion vest) | Select |  |  |  |
| Postural Drainage | Select |  |  |  |
| Nebulizer | Select |  |  |  |
| Tracheal aerosol therapy | Select |  |  |  |
| Oral suctioning that does not extend beyond the oral cavity | Select |  |  |  |
| Airway suctioning | Select |  |  |  |
| Tracheal suctioning | Select |  |  |  |
| Nasopharyngeal suctioning | Select |  |  |  |
| Other suctioning | Select |  |  |  |
| Tracheostomy care | Select |  |  |  |
| Care for central line | Select |  |  |  |
| Intravenous (IV) injections/infusions | Select |  |  |  |
| Subcutaneous injections | Select |  |  |  |
| Jejunostomy tube | Select |  |  |  |
| Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube) | Select |  |  |  |
| Indwelling or suprapubic catheter monitoring | Select |  |  |  |
| Insertion of catheter (intermittent catheterization) | Select |  |  |  |
| CPAP / BiPAP | Select |  |  |  |
| Oxygen therapy | Select |  |  |  |
| Colostomy, Ostomy, and/or other ostomy | Select |  |  |  |
| Peritoneal Dialysis | Select |  |  |  |
| Hemodialysis | Select |  |  |  |
| Active cerebral shunt monitoring | Select |  |  |  |
| Baclofen pump | Select |  |  |  |
| Wound care, excluding stage III or IV ulcers | Select |  |  |  |
| Treatment for stage III or IV ulcers (full los of skin and tissue, may extend into muscle or bone) | Select |  |  |  |
| Behavioral health therapies, including mental health | Select |  |  |  |
| Psychiatric therapies/services | Select |  |  |  |
| Other | Select |  |  |  |
| Other | Select |  |  |  |
| Other | Select |  |  |  |

|  |
| --- |
| #46 Notes: Click or tap here to enter text. |

## 47. Medication Management:

**(a)** Individual currently takes prescription medications or routine over-the-counter medications recommended by a medical professional:  Yes  No

(b) Does the individual take medication known to cause dehydration:  Yes  No

**Skip meds for under 18yo**

**(c)** Oral meds: Select

**(d)** Inhalant/Mist meds: Select

**(e)** Injectable meds: Select

**(f)** Topical meds: Select

**(g)** Suppository meds: Select

**(h)** Meds thru tube: Select

|  |
| --- |
| #47 Notes: Click or tap here to enter text. |

|  |
| --- |
| **Additional Assessment Notes:** Click or tap here to enter text. |