

Oregon Needs Assessment (ONA)

Version-2, Draft

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Key
Green: Skip patterns
Red: Additional instructions
Orange: Items/sections that will be skipped for children, variable age ranges

I. Assessment & Demographic Information

ASSESSMENT INFORMATION

Assessment ID:

Status:

Assessment type:

- Annual (new assessment)
- Annual (review assessment)
- Change in Need
- Request
- New to Service

Date of Assessment Interview: _____

Date of Face-to-Face Observation: _____

Date of Documentation Review: _____

Date Assessment Completed: _____

DEMOGRAPHICS

Client Prime: [Auto-populate, via Create operation]

Gender: [Auto-populate]

Legal Name: [Auto-populate]

Birth Date: [Auto-populate]

Age: [Auto-populate]

Address: _____

City: _____

Zip Code: _____

Phone: _____

Parent/Guardian: _____

Vision function (with correction):

- Adequate
- Mildly to Moderately Impaired
- Severely Impaired

- Unable to Assess
- Unknown

Hearing function (with correction):

- Adequate
- Mildly to Moderately Impaired
- Severely Impaired
- Unable to Assess
- Unknown

ASSESSOR AND CASE MANAGEMENT ENTITY INFORMATION

Service Setting:

Family or Own Home

- Comp In-Home (SE 49)
- Brokerage In-Home (SE 149)
- Supported Living (SE 51)
- Children’s In-Home Services (SE 151)
- Children’s Intensive In-Home (SE 145)
- Foster Care (SE 58)
- 24-hour Group Home
 - 24hr Residential (SE 50)
 - SACU (SE 141)
 - Children’s Residential System (SE 142)
- Other: _____

CIIS or Children’s Residential Coordinator: _____

Phone: _____

Email: _____

Service Coordinator/Personal Agent: _____

Case Management County:

Dropdown menu options:

- | | | | |
|-------------|--------------|-------------|--------------|
| ➤ Baker | ➤ Gilliam | ➤ Lincoln | ➤ Union |
| ➤ Benton | ➤ Grant | ➤ Linn | ➤ Wallowa |
| ➤ Clackamas | ➤ Harney | ➤ Malheur | ➤ Wasco |
| ➤ Clatsop | ➤ Hood River | ➤ Marion | ➤ Washington |
| ➤ Columbia | ➤ Jackson | ➤ Morrow | ➤ Wheeler |
| ➤ Coos | ➤ Jefferson | ➤ Multnomah | ➤ Yamhill |
| ➤ Crook | ➤ Josephine | ➤ Polk | ➤ CIIS |
| ➤ Curry | ➤ Klamath | ➤ Sherman | ➤ Child Res. |
| ➤ Deschutes | ➤ Lake | ➤ Tillamook | |
| ➤ Douglas | ➤ Lane | ➤ Umatilla | |

Additional comments related to case management entity:

Assessor's Name: _____ **Change Assessor:**

Affiliation:

- Brokerage
 - CDDP
 - DHS ReBAR/Assessment Unit
 - ODDS Children's Residential
- ODDS CIIS
 - ODDS Staff
 - Regional Staff

INDIVIDUAL'S PARTICIPATION IN ASSESSMENT, SUPPORT NETWORK, AND PROVIDER INFORMATION

Did the individual participate in the Assessment?

- Yes No

Describe the type of involvement or why the individual was not able to participate:

People Who Attended the Assessment Interview or Contributed to the Assessment

	Relationship		
<p style="text-align: center;">Name/Role</p> <p style="text-align: center;">[Role Dropdown:]</p> <ul style="list-style-type: none"> ➤ Did not participate ➤ Participated in the assessment ➤ At the assessment but did not contribute ➤ Gave input outside of assessment 	<p style="text-align: center;">[Dropdown:]</p> <ul style="list-style-type: none"> ➤ Self ➤ Legal guardian ➤ Parent ➤ Family ➤ Friend ➤ Provider/Staff ➤ Behavior Specialist ➤ Nursing Professional ➤ Services Coordinator ➤ Regional MCL/Crisis Staff ➤ Child Welfare Staff ➤ SPD Kids Residential Coordinator ➤ Personal Agent 	Phone/Email	Lives with individual

	➤ CIIS		
	➤ Other		
i.			<input type="checkbox"/>
ii.			<input type="checkbox"/>
iii.			<input type="checkbox"/>
iv.			<input type="checkbox"/>
v.			<input type="checkbox"/>
vi.			<input type="checkbox"/>

Created By: _____ Created Date: _____

Last Updated By: _____ Last Updated Date: _____

II. Communication

1. Communication Devices and Preferences

a. How does the person communicate with others? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Verbal English | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> Verbal Spanish | <input type="checkbox"/> Facial expression |
| <input type="checkbox"/> Verbal other language,
specify: _____ | <input type="checkbox"/> Communication board |
| <input type="checkbox"/> Sign language | <input type="checkbox"/> Electronic device |
| <input type="checkbox"/> Writing/Braille | <input type="checkbox"/> Texting/email/social media |
| | <input type="checkbox"/> Other: _____ |

b. How do others communicate with the person? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Verbal English | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> Verbal Spanish | <input type="checkbox"/> Facial expression |
| <input type="checkbox"/> Verbal other language,
specify: _____ | <input type="checkbox"/> Communication board |
| <input type="checkbox"/> Sign language | <input type="checkbox"/> Electronic device |
| <input type="checkbox"/> Writing/Braille | <input type="checkbox"/> Texting/email/social media |
| | <input type="checkbox"/> Other: _____ |

c. Identify any other communication preferences or needs. Include issues with communication with reference to setting.

++Notes

2. Language Expression and Comprehension

a. Clarity of speech:

- Speech is always clear and easy to understand
- Speech is occasionally unclear or difficult to understand
- Speech is frequently unclear or difficult to understand
- Speech is never clear nor easy to understand
- Does not speak
- Unable to assess

b. Expression of ideas and wants with people the individual is familiar with:

- Expresses complex messages without difficulty
- Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts)
- Frequently exhibits difficulty with expressing needs and ideas
- Rarely/Never expresses self
- Unable to assess

c. Expression of ideas and wants with people the individual is unfamiliar with:

- Expresses complex messages without difficulty
- Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts)
- Frequently exhibits difficulty with expressing needs and ideas
- Rarely/Never expresses self
- Unable to assess

d. Is the individual able to ask for something to drink or indicate he or she is thirsty?

- Yes
- No, describe why unable: _____

e. Understanding verbal content (excluding language barriers)

- Understands - Clear comprehension without cues or repetitions
- Usually Understands - Understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- Sometimes Understands - Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- Rarely/Never Understands
- Unable to assess

++Notes

III. ADLs and IADLs

3. Dressing

{Item 3 is skipped for all individuals under the age of 4}

a. Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

c. Putting on/taking off footwear - The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance

- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

**d. Preferences (optional) – What does the individual prefer when dressing?
(Check all that apply)**

- | | |
|---|---|
| <input type="checkbox"/> Changes clothes multiple times daily | <input type="checkbox"/> Same clothing daily |
| <input type="checkbox"/> Choose own clothes | <input type="checkbox"/> Velcro closures |
| <input type="checkbox"/> Female support person | <input type="checkbox"/> Wears loose clothing |
| <input type="checkbox"/> Male support person | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Other _____ |

e. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with dressing (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Able to direct support person | <input type="checkbox"/> Able to manage his/her own need |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Persons providing support put on/take off footwear |
| <input type="checkbox"/> Can button clothing | <input type="checkbox"/> Persons providing support put on/take off sock/TED hose |
| <input type="checkbox"/> Can lift arms | <input type="checkbox"/> Two-person assist |
| <input type="checkbox"/> Medical/physical symptoms interfere with performing task | <input type="checkbox"/> Able to tie |
| <input type="checkbox"/> Persons providing support dress individual's lower body | <input type="checkbox"/> Able to zip |
| <input type="checkbox"/> Persons providing support dress individual's upper body | <input type="checkbox"/> Uses assistive device |
| <input type="checkbox"/> Gets dressed with cueing | <input type="checkbox"/> Will attempt to wear dirty clothes |
| <input type="checkbox"/> Persons providing support help select appropriate, clean, and/or matching clothes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Persons providing support label/organize clothing by color, style, etc. | |

++Notes

4. Transferring and Positioning

{Item 4 is skipped for all individuals under the age of 3}

a. Sit to stand - The ability to safely come to a standing position from sitting in a chair or on the side of the bed.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Chair/bed to chair transfer - The ability to safely transfer to and from a bed to a chair (or wheelchair).

- 06 Independent (Skip to 5)
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

c. Roll left and right - The ability to roll from lying on back to left and right side, and return to lying on back.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

d. Preferences (optional) – How does the individual prefer to be transferred and positioned? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Support persons use a gait belt | <input type="checkbox"/> Weight bearing transfer |
| <input type="checkbox"/> Someone to assist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mechanical and/or ceiling lifts | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Use a transfer board/pole | |

e. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with transferring and positioning (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Asks for assistance | <input type="checkbox"/> Regular repositioning required |
| <input type="checkbox"/> Persons providing support assist with all wheelchair transfers | <input type="checkbox"/> Persons providing support should talk individual through each transfer |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Transfer quickly |
| <input type="checkbox"/> Can transfer self using a lift | <input type="checkbox"/> Transfer slowly |
| <input type="checkbox"/> Persons providing support cue to use adaptive equipment | <input type="checkbox"/> Transfers with some support |
| <input type="checkbox"/> Medical/physical symptoms interfere with performing task | <input type="checkbox"/> Two-person transfer |
| <input type="checkbox"/> Has good upper body strength | <input type="checkbox"/> Steady during transfer |
| <input type="checkbox"/> Persons providing support maintain contact until steady | <input type="checkbox"/> Use mechanical lift for ALL transfers |
| <input type="checkbox"/> Individual able to manage his/her own need | <input type="checkbox"/> Use transfer board for transfers |
| | <input type="checkbox"/> Other _____ |

++Notes

5. Mobility

{Item 5 is skipped for all individuals under the age of 3}

a. Does the person walk?

- Yes
- No, and walking goal is not indicated (Skip to item e)
- No, and walking is indicated in future (Skip to item e)

b. Walks 150 feet - Once standing, the ability to walk at least 150 feet in a corridor or similar space.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

c. Step onto/off of a curb - The ability to step on/off a curb or up/down one step.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

d. 12 steps - The ability to go up and down 12 steps with or without a rail.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

e. Does the person use a wheelchair or scooter?

- Yes
- No, unmet need (Skip to item f)

No, does not use (Skip to item g)

>>**Type of wheelchair/scooter used**

- Manual
 Motorized

f. Wheels 150 feet - Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

- 06 Independent
 05 Setup or clean-up assistance
 04 Supervision or touching assistance
 03 Partial/moderate assistance
 02 Substantial/maximal assistance
 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
 09 Not applicable
 88 Not attempted due to medical condition or safety concerns

g. Has the individual had two or more falls in the past year?

- Yes
 No
 Unknown

h. Has the individual ever had fall(s) that resulted in major injury (fracture, sprain, head injury, or ongoing pain)?

- Yes, type (Check all that apply)
 Fracture
 Head injury
 Other: _____
 No
 Unknown

i. Preferences (optional) – What does the individual prefer when needing to move about? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Can walk, but prefers wheelchair | <input type="checkbox"/> Pushed in wheelchair |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Contact guard when walking | <input type="checkbox"/> Walker with fold-down seat |
| <input type="checkbox"/> Crutch | <input type="checkbox"/> Walker with permanent seat |
| <input type="checkbox"/> Electric wheelchair | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gait belt | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Manual wheelchair | |

j. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual to move about (Check all that apply)

- Access to backup equipment or same day repair necessary
- Individual is afraid of falling
- Persons providing support 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
- Persons providing support keep walkways clear
- Individual leans to one side
- Persons providing support leave assistive device within reach
- Individual able to manage his/her own need
- Good navigation
- Persons providing support provide contact guard when walking
- Persons providing support provide physical support with stairs
- Persons providing support should 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
- Persons providing support hold the gait belt to steady the individual
- Other: _____
- Other: _____

++Notes

6. Eating and Tube Feeding

a. Nutritional approaches (Check all that apply)

- Parenteral/IV feeding {Skip item 6.c below if this answer and the next one are not selected}
- Feeding tube - nasogastric or abdominal (e.g., gastrostomy or jejunostomy) {Skip item 6.c below if this answer and the previous one are not selected}
- Mechanically altered food/fluid - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- None of the above

{Item 6.b is skipped for all individuals under the age of 4}

b. Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

06 Independent

- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

c. Tube Feeding - The ability to manage all equipment/supplies related to obtaining nutrition. - Skip item 6.c if both of the 6.a answers "Parenteral/IV feeding" and "Feeding tube" are not selected

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

d. Preferences (optional) – What does the individual prefer when eating and/or tube feeding? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Bland diet | <input type="checkbox"/> Use own recipes |
| <input type="checkbox"/> Cold food | <input type="checkbox"/> Support person to inject formula slowly |
| <input type="checkbox"/> Eat/tube feed alone | <input type="checkbox"/> Tube feeding to be done discretely |
| <input type="checkbox"/> Eat/tube feed with others present | <input type="checkbox"/> Environmental preferences – likes to be warm, watch TV, etc. |
| <input type="checkbox"/> Finger foods | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hot food | |
| <input type="checkbox"/> Large portions | |
| <input type="checkbox"/> Small portions | |
| <input type="checkbox"/> Snacks | |

e. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with eating and/or tube feeding (Check all that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Can cut food |
|---|---------------------------------------|

- Persons providing support cut food into small pieces
- Medical/physical symptoms interfere with performing task
- Has a good appetite
- Independent with equipment/adaptations
- Individual has food allergies
- Persons providing support monitor liquids
- Individual has mouth pain
- Persons providing support provide cues for eating
- Uses tube feeding pump
- Uses gravity method
- Uses syringe method
- Strategic timing of tube feeding to maximize participation in other activities
- 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? (Check all that apply)

- Complains of difficulty or pain with swallowing
- Coughing or choking during meals or when swallowing medications
- Holding food in mouth/cheeks or residual food in mouth after meals
- Loss of liquids/solids from mouth when eating or drinking
- NPO - nothing by mouth
- Other (specify): _____
- None of the above

g. Does the individual refuse food or liquids because of food preferences or sensory issues, such as texture or taste?

- Yes, describe: _____
- No

h. Does the individual drool excessively?

- Yes
- No

i. Does the individual complain of chest pain, heartburn, or have small, frequent vomiting (especially after meals) or unusual burping (happens frequently or sounds wet)?

- Yes
- No

j. Has the individual required intravenous (IV) fluids due to dehydration in the past year?

- Yes
- No

++Notes**7. Elimination****{Item 7.a is skipped for all individuals under the age of 4}****a. Toilet hygiene - The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal.**

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 7.b is skipped for all individuals under the age of 4}**b. Toilet transfer - The ability to safely get on and off a toilet or commode.**

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 7.c is skipped for all individuals under the age of 4}**c. Preferences (optional) – What does the individual prefer when being supported to stay dry and clean? (Check all that apply)**

- | | |
|--|--|
| <input type="checkbox"/> Adult protection/absorbent products | <input type="checkbox"/> Bed pan only |
| <input type="checkbox"/> Diapers | <input type="checkbox"/> Bedside commode |
| | <input type="checkbox"/> Female support person |

- Male support person
- Pads/briefs when going out
- Specific products
- Urinal
- Other _____

{Item 7.d is skipped for all individuals under the age of 4}

d. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with toileting (Check all that apply)

- Able to use incontinence products
- Aware of need to use toilet
- Behavioral health challenges
- Persons providing support 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
- Assists support person with transfer
- Experiences urgency
- Painful urination
- Will use pads/briefs
- Two-person assist
- Condom catheter used with support person assistance
- Pads changed by support person, as needed
- Medical/physical symptoms interfere with performing task
- Other _____

e. Have there been any issues around constipation during the last year?

- Yes
- No (Skip to item 8)

f. Does the individual take routine bowel medications for constipation or take “as needed” (PRN) medications for constipation more than two times a month within the past year (do not include fiber)?

- Yes
- No

g. Does the individual have a diagnosis of chronic constipation or have ongoing issues with constipation?

- Yes
- No

h. Has the individual required a suppository or enema for constipation within the past year?

- Yes
- No

i. Does the individual require digital impaction removal by the support person five or more days per week?

- Yes
- No

j. Has the individual had more than one episode in the past year of complaining of pain when having a bowel movement?

- Yes
- No

k. Has the individual had more than one known episode of hard stool in the past year?

- Yes
- No

l. Does the individual take a medication that causes constipation and would not recognize or communicate if he/she was constipated?

- Yes: _____
- No

++Notes

8. Showering and Bathing

{Item 8 is skipped for all individuals under the age of 5}

a. Shower/bathe self - The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Include transferring in/out of tub/shower.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer when bathing?
(Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Bath | <input type="checkbox"/> Shower |
| <input type="checkbox"/> Bed bath | <input type="checkbox"/> Sponge bath |
| <input type="checkbox"/> Female support person | <input type="checkbox"/> Specific products |
| <input type="checkbox"/> Male support person | <input type="checkbox"/> Other _____ |

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with bathing (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Able to direct support person | <input type="checkbox"/> Persons providing support give bed/sponge bath |
| <input type="checkbox"/> Able to manage his/her own needs | <input type="checkbox"/> Individual is weight bearing |
| <input type="checkbox"/> Afraid of bathing | <input type="checkbox"/> Skin checks are completed by support person |
| <input type="checkbox"/> Persons providing support assist with drying and dressing | <input type="checkbox"/> Persons providing support soak the individual's feet |
| <input type="checkbox"/> Bathes self with cueing | <input type="checkbox"/> Standby during bathing |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Two-person assist |
| <input type="checkbox"/> Can be left unattended | <input type="checkbox"/> Able to transfer in/out of tub/shower |
| <input type="checkbox"/> Can judge water temperature | <input type="checkbox"/> Able to shampoo hair |
| <input type="checkbox"/> Can adjust water temperature | <input type="checkbox"/> Able to stand alone |
| <input type="checkbox"/> Medical/physical symptoms interfere with performing task | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Enjoys bathing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Persons providing support wash the individual's back, legs, feet | |

++Notes

9. Oral Hygiene

{Item 9 is skipped for all individuals under the age of 5}

a. Oral Hygiene - The ability to use suitable items to clean teeth. [Dentures (if applicable) - The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer regarding oral hygiene? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Assistance after eating | <input type="checkbox"/> Prefers a female support person |
| <input type="checkbox"/> Assistance during morning routine | <input type="checkbox"/> Prefers a male support person |
| <input type="checkbox"/> Assistance before bedtime | <input type="checkbox"/> Electric toothbrush |
| | <input type="checkbox"/> Other _____ |

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with oral hygiene (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Able to manage his/her own need | <input type="checkbox"/> Medical/physical symptoms interfere with performing task |
| <input type="checkbox"/> Persons providing support cue to brush teeth | <input type="checkbox"/> Aware of hygiene needs |
| <input type="checkbox"/> Persons providing support assist to clean teeth/dentures | <input type="checkbox"/> Behavioral health challenges |
| | <input type="checkbox"/> Other _____ |

++Notes**10. General Hygiene****{Item 10 is skipped for all individuals under age 5}****a. General Hygiene - The ability to perform other hygiene maintenance tasks, such as hair brushing, shaving, nail care, and applying deodorant. Note: Excludes toilet, and oral hygiene.**

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial /moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable

○ 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer regarding general hygiene? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Assistance after eating | <input type="checkbox"/> Electric razor |
| <input type="checkbox"/> Assistance during morning routine | <input type="checkbox"/> Prefers a female support Person |
| <input type="checkbox"/> Assistance before bedtime | <input type="checkbox"/> Prefers a male support person |
| | <input type="checkbox"/> Other _____ |

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with general hygiene (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Able to manage his/her own need | <input type="checkbox"/> Individual knows how to use feminine hygiene products |
| <input type="checkbox"/> Support person applies the individual’s deodorant | <input type="checkbox"/> Persons providing support shave the individual daily or as needed |
| <input type="checkbox"/> Support person combs the individual’s hair as needed | <input type="checkbox"/> Persons providing support trim the individual’s fingernails as needed |
| <input type="checkbox"/> Able to comb hair | <input type="checkbox"/> Aware of hygiene needs |
| <input type="checkbox"/> Able to wash face/hands | <input type="checkbox"/> Behavioral health challenges |
| <input type="checkbox"/> Medical/physical symptoms interfere with performing task | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Needs reminders to use/change feminine hygiene products | |

++Notes

11. ADL Equipment

a. ADL Equipment: Does the individual have or need any adaptive equipment to assist with ADLs?

Type	Current usage [Dropdown:] ➤ Does not need ➤ Needs but does not have ➤ Has but does not use ➤ Uses less than daily ➤ Uses daily	Support Person assists with equipment	Comments
Mechanical lift (e.g. Hoyer lift)	[Dropdown]	<input type="checkbox"/>	_____
Prone stander	[Dropdown]	<input type="checkbox"/>	_____

Type	Current usage [Dropdown:] ➤ Does not need ➤ Needs but does not have ➤ Has but does not use ➤ Uses less than daily ➤ Uses daily	Support Person assists with equipment	Comments
Sidelyer	[Dropdown]	<input type="checkbox"/>	<hr/>
Body jacket	[Dropdown]	<input type="checkbox"/>	<hr/>

++Notes

12. Housework

{Item 12 is skipped for all individuals under the age of 12}

a. Housework - The ability to safely and effectively maintain cleanliness of the living environment by washing cooking and eating utensils; changing bed linens; dusting; cleaning the stove, sinks, toilets, tubs/showers, and counters; sweeping, vacuuming, and washing floors; and taking out garbage.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer when performing housework? (Check all that apply)

- | | |
|--|---------------------------------|
| <input type="checkbox"/> Likes a neat house | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Wants items left where they are | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Prefers others to complete | |

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with performing housework (Check all that apply)

- 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
- Medical/physical symptoms interfere with performing task
- Persons providing support dust/vacuum as needed
- Individual has chemical sensitivities
- Persons providing support mow lawn as needed
- Individual can make or change bedding
- Individual can see when surfaces need cleaning
- Persons providing support change/wash linens weekly
- Support person cue the individual to perform tasks
- Persons providing support shovel snow as needed
- Persons providing support sweep/mop floors as needed
- Persons providing support take out garbage
- Other:

++Notes

13. Meal Preparation

{Item 13 is skipped for all individuals under the age of 12}

a. Make a light meal - The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer related to meal preparation? (Check all that apply)

- 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
 - Large portions
 - Other religious/ethnic foods
 - Salt-free foods
 - Small portions
 - Sugar-free foods
 - Vegetarian diet
 - Vegan diet
 - Other therapeutic diet: _____
 - Other: _____
- Smaller meals, more than three times per day

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with preparing meals (Check all that apply)

- 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 support person to prepare meal
- Individual needs assistance when using kitchen
- Medical/physical symptoms interfere with performing task
- Persons providing support prepare meals for individual to reheat
- Individual knows how to cook
- Individual has food allergies
- Individual has accessible kitchen
- Individual keeps spoiled food
- Persons providing support label/organize food products
- Individual leaves burners on
- Individual makes appropriate meal choices
- Persons providing support make food accessible to the individual
- Persons providing support prepare all meals
- Individual has special diet
- Work out a menu with individual
- Other: _____

++Notes

14. Laundry

{Item 14 is skipped for all individuals under the age of 12}

a. Laundry - Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, adding laundry detergent, and folding laundry.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance

- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Preferences (optional) – What does the individual prefer when doing laundry? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Prefers to fold certain items, describe: _____ | <input type="checkbox"/> Wants items left where they are |
| <input type="checkbox"/> Prefers others to complete | <input type="checkbox"/> Other: |

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with doing laundry (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Individual has allergies to certain detergents or soaps | <input type="checkbox"/> Individual can operate washer/dryer |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Persons providing support cue the individual to perform tasks |
| <input type="checkbox"/> Individual can fold clothes | <input type="checkbox"/> Medical/physical symptoms interfere with performing task |
| <input type="checkbox"/> Individual can instruct support person | <input type="checkbox"/> Other: |

++Notes

15. Transportation

{Item 15.a is skipped for all individuals under the age of 12}

a. Use public transportation - The ability to plan and use public transportation. Includes boarding, riding, and disembarking from transportation.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused

- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 15.b is skipped for all individuals under the age of 3}

b. Car transfer - The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

c. Preferences (optional) – What does the individual prefer related to transportation? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Accessible bus | <input type="checkbox"/> Use own car, other person drives |
| <input type="checkbox"/> Bike | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Taxi | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Ride sharing | |
| <input type="checkbox"/> Use own car, individual drives | |

d. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with transportation activities (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Persons providing support accompany person on bus/van | <input type="checkbox"/> Persons providing support make arrangements for accessible bus |
| <input type="checkbox"/> Persons providing support arrange medical transportation | <input type="checkbox"/> Persons providing support take portable oxygen tank |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Persons providing support take wheelchair/walker |
| <input type="checkbox"/> Individual able to communicate with drivers | <input type="checkbox"/> Persons providing support assist with securing wheelchair in accessible vehicle |
| <input type="checkbox"/> Persons providing support use own car/agency vehicle | <input type="checkbox"/> Medical/physical symptoms interfere with performing task |
| <input type="checkbox"/> Persons providing support drive individual to appointments | <input type="checkbox"/> Individual needs orientation and mobility training for new routes |
| <input type="checkbox"/> Has disabled parking permit | |
| <input type="checkbox"/> Knows bus routes | |

- | | |
|---|--|
| <input type="checkbox"/> Individual able to arrange own transportation | <input type="checkbox"/> Support person assists the individual to use vest/harness |
| <input type="checkbox"/> Persons providing support use supportive seating | <input type="checkbox"/> Other: _____ |

++Notes

16. Money Management

{Item 16 is skipped for all individuals under the age of 12}

a. Money Management - The ability to manage finances for basic necessities (food, clothing, shelter), including counting money and making change, paying bills/writing checks, making budgeting and other financial decisions, and balancing checkbook.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

b. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with finances (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Able to budget income and expenses | <input type="checkbox"/> Individual signs own checks |
| <input type="checkbox"/> Persons providing support arrange credit counseling | <input type="checkbox"/> Medical/physical symptoms interfere with performing task |
| <input type="checkbox"/> Support person balances individuals checkbook monthly | <input type="checkbox"/> Has a representative payee |
| <input type="checkbox"/> Behavioral health challenges | <input type="checkbox"/> Has direct deposit |
| <input type="checkbox"/> Persons providing support contact POA regarding finance issues | <input type="checkbox"/> Has guardian/POA |
| <input type="checkbox"/> Support person contacts representative payee regarding financial issues | <input type="checkbox"/> Needs Power of Attorney (POA) |
| | <input type="checkbox"/> Can use EBT card |
| | <input type="checkbox"/> Can use debit card |
| | <input type="checkbox"/> Can write checks and pay bills |
| | <input type="checkbox"/> Can see/read bills and account information |

- | | |
|--|--|
| <input type="checkbox"/> Support person pays bills for the individual | <input type="checkbox"/> Needs utility payment set up |
| <input type="checkbox"/> Needs automatic payment plan set up | <input type="checkbox"/> Vulnerable to financial exploitation |
| <input type="checkbox"/> Needs assistive/adaptive equipment to see paperwork | <input type="checkbox"/> Relies on others to understand that money has value |
| <input type="checkbox"/> Needs budget set up | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Other: |

++Notes

17. Light Shopping

{Item 17 is skipped for all individuals under the age of 12}

a. Light shopping - Once at store, can locate and select up to five groceries and personal care items, take to check out, and complete purchasing transaction.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

**e. Preferences (optional) – What does the individual prefer related to shopping?
(Check all that apply)**

- Shop at a specific store
- Shop weekly
- Specialty items
- Use coupons
- Other:
- Other:

c. Guidance for Individuals Providing Support (optional) – Factors to consider when assisting the individual with shopping (Check all that apply)

- Able to communicate with store personnel
- Persons providing support 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
- Support person assists with comparison shopping
- Persons providing support do all shopping for the individual
- Support person guides individual within store, find/describe items
- Persons providing support help individual make shopping list
- Persons providing support read labels to the individual
- Persons providing support put items away
- Persons providing support take the individual to store
- Other:
- Other:

++ Notes

IV. Behaviors

18. Injurious to Self

a. Individual displays, or would without intervention, disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs).

- No history, no concern about this behavior [Skip to 19.a]
 Has history, has not displayed symptoms in past year, no concern about reoccurrence
 Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
 No history, but assessor has concerns may become an issue. [Skip to 18.b]
 Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Chemical abuse/misuse
 Cutting self
 Head-banging
 History of suicide attempts
 Fascination with fire
 Pulling out hair
 Puts self in dangerous situations that cause or may cause harm or injury (must be intentional to harm self and harm must be immediate)
 Self-biting
 Self-burning
 Self-hitting
 Self-poking/stabbing/picking
 Self restricts eating
 Other, describe in 18.b

b. Description of behaviors and/or any potential concerns _____**c. Description of intermittent/cyclical behaviors, if applicable** _____**++Notes** _____

19. Aggressive or Combative

a. Individual displays physical behavior symptoms, or would without intervention, directed toward others (e.g., hits, kicks, pushes, or punches others, throws objects, spitting).

- No history, no concern about this behavior [Skip to 20.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 19.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Bites
- Hits/punches
- Kicks
- Pulls other's hair
- Pushes
- Scratches
- Throws objects at others
- Unwanted touching of others (rough Play)
- Tripping
- Uses objects to hurt others
- Other, describe in 19.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

20. Injurious to Animals

a. Individual displays, or would without intervention, behaviors that would result in the injury of an animal.

- No history, no concern about this behavior [Skip to 21.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 20.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Rough pulling on limbs or body of animal

- Attempts to maim or kill animals
- Sexual abuse against animals
- Other, describe in 20.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

21. Aggressive Towards Others, Verbal

a. Individual displays, or would without intervention, verbal behavioral symptoms directed towards others (e.g., yelling, screaming, threatening, cursing, excessive profanity, sexual references).

- No history, no concern about this behavior [Skip to 22.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 21.b]
- Yes, present in past year

>>Presenting behaviors (Check all that apply)

- Attempts to intimidate through aggressive gestures with no physical contact
- Goads
- Intimidates/stares
- Manipulates others - verbal/gestural
- Resists care
- Swears at others
- Taunts/teases
- Verbal Threats
- Writes threatening notes (includes electronic or other)
- Yells/screams at others
- Other, describe in 21.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

22. Socially Unacceptable Behavior

a. Individual expresses him/herself, or would without intervention, in an inappropriate or unacceptable manner. Includes disruptive or socially inappropriate behavior (e.g., inappropriate sexual comments or other behaviors, smearing/throwing food or feces)

- No history, no concern about this behavior [Skip to 23.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 22.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Disrupts other's activities
- Does not understand personal boundaries
- Spits
- Throws food
- Urinates/defecates in inappropriate places
- Screams or vocalizes loudly (not related to aggression)
- Exposes private body areas to others
- Inappropriately touches others (unlikely to lead to arrest)
- Masturbates in public
- Unwanted touching of others
- Other, describe in 22.b

b. Description of behaviors and/or any potential concerns _____

c. Description of intermittent/cyclical behaviors, if applicable _____

++Notes _____

23. Sexual Aggression/Assault

a. Individual displays, or would without intervention, behaviors that are sexually aggressive (e.g., grabbing, thrusting) or assaultive (e.g., pushing up against wall and groping) towards others.

- No history, no concern about this behavior [Skip to 24.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 23.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Inappropriately touches/gropes others

<input type="checkbox"/> Unwanted touching of others (could lead to arrest) <input type="checkbox"/> Forcible attempts to engage others in sexual acts <input type="checkbox"/> Pedophilia <input type="checkbox"/> Targets vulnerable population <input type="checkbox"/> Other, describe in 23.b
b. Description of behaviors and/or any potential concerns _____
c. Description of intermittent/cyclical behaviors, if applicable _____
++Notes _____
24. Property Destruction
<p>a. Individual engages in behavior, or would without intervention, that disassembles or damages public or private property or possessions. The individual is intentionally engaging in an act that leads to damage, though may not have the intent to cause damage.</p> <p> <input type="radio"/> No history, no concern about this behavior [Skip to 25.a] <input type="radio"/> Has history, has not displayed symptoms in past year, no concern about reoccurrence <input type="radio"/> Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence <input type="radio"/> No history, but assessor has concerns may become an issue. [Skip to 24.b] <input type="radio"/> Yes, present in past year {If selected, don't skip item 36 below} </p> <p>>>Presenting behaviors (Check all that apply)</p> <p> <input type="checkbox"/> Breaks windows, glass, lamps or furniture <input type="checkbox"/> Punches holes in walls <input type="checkbox"/> Sets fires <input type="checkbox"/> Uses tools/objects to damage property <input type="checkbox"/> Targets other's property <input type="checkbox"/> Breaks small objects <input type="checkbox"/> Cuts electronic cords <input type="checkbox"/> Tears clothing <input type="checkbox"/> Other, describe in 24.b </p>
b. Description of behaviors and/or any potential concerns _____
c. Description of intermittent/cyclical behaviors, if applicable _____
++Notes _____

25. Leaving Supervised Area

a. Individual leaves, or would without intervention, an area or group without telling others or departs from the support person unexpectedly, resulting in increased vulnerability.

- No history, no concern about this behavior [Skip to 26.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 25.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Wanders away from a 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 25.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

26. Pica (ingestion of non-nutritive substances) and/or Placing Non-Edible Objects in Mouth

a. Does not require diagnosis of Pica, only presenting behaviors. Individual ingests, or would without an intervention, non-food items (e.g., liquid detergent, coins, paper clips, cigarettes) or the individual places non-edible objects in his/her mouth that may cause poisoning, aspiration, choking and/or severe injury.

- No history, no concern about this behavior [Skip to 27.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 26.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Typically ingests: (Check all that apply)

- Dirt
- Glass
- Stones
- Paper

- Hair
- Urine
- Feces
- Wood
- Toxic substances (e.g., soap, cleaning solutions)
- Cigarettes
- Other, describe in 26.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

27. Difficulties Regulating Emotions

a. Individual has instances, or would without intervention, of emotional behavior that are atypical of others in similar situations.

- No history, no concern about this behavior [Skip to 28.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 27.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- 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 27.b

b. Description of behaviors and/or any potential concerns_____

c. Description of intermittent/cyclical behaviors, if applicable_____

++Notes _____

28. Refusing ADL/IADL and/or Medical Care**a. Individual resists required assistance, or would without intervention (e.g., resists ADL assistance or medications).**

- No history, no concern about this behavior [Skip to 29.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 28.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Is physically combative against assistance
- Is verbally combative against assistance
- Is resistant against specific ADL/IADL assistance, describe in 28.b
- 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 28.b

b. Description of behaviors and/or any potential concerns _____**c. Description of intermittent/cyclical behaviors, if applicable** _____

++Notes _____

29. Rapid Ingestion of Food or Liquids**a. Rapidly ingests food or liquids, or would without intervention, that presents a health or safety risk to the individual.**

- No history, no concern about this behavior [Skip to 30.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 29.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Rapid ingestion of liquids
- Rapid ingestion of foods
- Behavior only present with specific foods/liquids, describe in 29.b

<input type="checkbox"/> Other, describe in 29.b
b. Description of behaviors and/or any potential concerns _____
c. Description of intermittent/cyclical behaviors, if applicable _____
++Notes _____
30. Withdrawal
<p>a. Individual has a tendency, or would without intervention, to avoid, isolate or retreat from conversation, interaction or activity.</p> <p><input type="radio"/> No history, no concern about this behavior [Skip to 31.a]</p> <p><input type="radio"/> Has history, has not displayed symptoms in past year, no concern about reoccurrence</p> <p><input type="radio"/> Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence</p> <p><input type="radio"/> No history, but assessor has concerns may become an issue. [Skip to 30.b]</p> <p><input type="radio"/> Yes, present in past year {If selected, don't skip item 36 below}</p> <p>>>Presenting behaviors (Check all that apply)</p> <p><input type="checkbox"/> Avoidance</p> <p><input type="checkbox"/> Isolation</p> <p><input type="checkbox"/> Lack of interest in life events</p> <p><input type="checkbox"/> Other, describe in 30.b</p>
b. Description of behaviors and/or any potential concerns _____
c. Description of intermittent/cyclical behaviors, if applicable _____
++Notes _____

31. Intrusiveness

a. Individual has a tendency, or would without intervention, for entering personal or private space without regard or permission.

- No history, no concern about this behavior [Skip to 32.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 31.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Inappropriate boundaries
- Physical
- Verbal
- Inappropriate eye contact (e.g., extended periods of time)
- Unaware of interpersonal space
- Other, describe in 31.b

b. Description of behaviors and/or any potential concerns _____

c. Description of intermittent/cyclical behaviors, if applicable _____

++Notes _____

32. Susceptibility to Victimization

a. Individual engages in, or would without intervention, behaviors that increase or could potentially increase the individual's level of risk of harm or exploitation by others, such as befriending strangers.

- No history, no concern about this behavior [Skip to 33.a]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 32.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Examples of behaviors that may increase susceptibility, but are not limited to these (Check all that apply)

- Hitchhiking
- Inviting strangers into their home
- Panhandling
- Promiscuity
- Puts self in harm's way

- Shares personal identifying information
 Other, describe in [32.b](#)

b. Description of behaviors and/or any potential concerns _____

c. Description of intermittent/cyclical behaviors, if applicable _____

++Notes _____

33. Legal Involvement

a. Individual has been engaged with or is at risk of being engaged with law enforcement or Psychiatric Security Review Board (PSRB), arrested, and/or convicted of breaking a law or laws and has been determined to have had knowledge of breaking laws.

- No history, no concern about this behavior [[Skip to 34.a](#)]
 Has history, has not displayed symptoms in past year, no concern about reoccurrence
 Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
 No history, but assessor has concerns may become an issue. [[Skip to 33.b](#)]
 Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Assault
 Burglary
 Commits arson
 Issues related to homelessness (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 33.b

b. Description of behaviors and/or any potential concerns _____

c. Description of intermittent/cyclical behaviors, if applicable _____

++Notes _____

34. Other Behavior Issues**a. Describe:**

- No history, no concern about this behavior [Skip to 36]
- Has history, has not displayed symptoms in past year, no concern about reoccurrence
- Has history, has not displayed symptoms in past year, assessor has concerns about reoccurrence
- No history, but assessor has concerns may become an issue. [Skip to 34.b]
- Yes, present in past year {If selected, don't skip item 36 below}

>>Presenting behaviors (Check all that apply)

- Fecal smearing
- Hoarding
- False reporting (with the intent of getting someone in trouble)
- Calls 911 inappropriately
- Problem gambling
- Other, describe in 34.b

b. Description of behaviors and/or any potential concerns _____**c. Description of intermittent/cyclical behaviors, if applicable** _____

++Notes _____

{NOTE: Question 35 is intentionally left blank}**36. Intervention Frequency****{Skip item 36 if none of the "Yes" answers are selected in questions 18 through 34}****How often does the individual require intervention and/or environment management due to any behavior issue (not specifically to each presenting behavior)?****a. Cueing**

- None
- Less than once per month
- Once per month
- More than once per month
- 1-3 times per week

- 4 or more times per week, but less than daily
- Less than 5 times per day
- More than 5 times per day

b. Proactive strategies and physical prompts

- None
- Less than once per month
- Once per month
- More than once per month
- 1-3 times per week
- 4 or more times per week, but less than daily
- Less than 5 times per day
- More than 5 times per day

c. Safeguarding interventions (also known as PPIs)

- None
- Less than once per month
- Once per month
- More than once per month
- 1-3 times per week
- 4 or more times per week, but less than daily
- Less than 5 times per day
- More than 5 times per day

++Notes

37. Other Behavior Items

a. Is a court mandated restriction currently in place against the individual?

- Yes. Describe the type of restriction, reason for restriction, and order date: _____
- No

b. Does the individual have a current court mandated restriction in place against anyone?

- Yes. Describe the type of restriction, reason for restriction, and order date: _____
- No

++Notes

38. Substance Abuse Issues

a. **Is there a concern about abuse of substances, including illegal drugs, marijuana, prescription medication, or alcohol?**

- Yes
- No (Skip to 39, Positive Behavior Support Plan)
- Chose not to answer (Skip to 39, Positive Behavior Support Plan)

>> **Which types of substances? (Check all that apply)**

- Alcohol
- Marijuana
- Prescription drugs
- Illegal drugs
- Other

>> **Describe use/abuse of substances**

++Notes

39. Positive Behavior Support Plan (PBSP)

a. **Has a Positive Behavior Support Plan (PBSP) (also known as Behavior Support Plan or BSP) been created for the individual?**

- Yes
- No (Skip to item f)

b. **Is the PBSP currently being implemented by support persons? (Support persons have been trained on the PBSP.)**

- Yes
- No (Skip to item f)

c. **Does the PBSP implementation include documentation of the incidence of behavior?**

- Yes
- No (Skip to item f)

d. **Does the PBSP include Safeguarding interventions (formerly known as Protective Physical Interventions or PPIs)?**

Yes

No

e. Does the individual's BSP include complex behavior support that must be developed or significantly altered by a support person one or more times per month (such as social stories or visual structure systems)?

Yes

No

f. Has the individual required emergency services, crisis intervention services or protective services to address a dangerous behavior 2 or more times in the past 12 months?

Yes

No

++Notes

--

V. Safety

40. Safety Awareness and Support

Item 40 is skipped for all individuals under the age of 5

a. Does the individual have the judgment and/or physical ability to cope, make appropriate decisions (e.g., selecting clothing appropriate for weather), and take action in a changing environment or a potentially harmful situation [assessor's judgment]?

- Yes
 No **(Check all that apply and describe below)**
- Judgment/decision-making: _____
 Physical ability: _____
 Behavior issue: _____

b. Does the individual need support to remain safe around traffic?

- Yes
 No

c. Does the individual need support to evacuate when a fire or smoke alarm sounds?

- Yes
 No

++Notes

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?

- No

Yes, describe: _____

c. Is the individual at risk of eviction because of conditions within the residence?

No

Yes, describe: _____

++Notes

42. Assessor's Judgment About Potential for Abuse, Neglect, and Exploitation

a. Is this individual at significantly increased risk, beyond the typical risk for an individual with I/DD, for neglect, abuse, or exploitation by another person?

No

Yes, describe reasons: _____

{Item 42.b is skipped for all individuals under the age of 18}

b. For individuals age 18 and over: Is this individual at risk of self-neglect?

No [Skip to item 43]

Yes, type: **(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: _____

{Item 42.c is skipped for all individuals over the age of 17}

c. For individuals under age 18: Has child welfare been involved on behalf of the individual?

No

Yes, describe: _____

++Notes

VI. Medical

43. General Medical Supports**{Item 43.a is skipped for individuals under the age of 18}**

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?

- None (Skip to b)
- One
- Two or three
- More than three

>>Select the reason(s) the individual did not seek attention for 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, including mental health 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 temperature, respiration, heart rate, and 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: _____

{Item 43.e is skipped for individuals under the age of 18}

e. Does the individual need assistance to make and/or keep medical appointments?

Yes, describe: _____

No

++Notes

44. Conditions and Diagnoses

Health Conditions/Specific Diagnoses	Has condition	Affects functioning	Receiving treatment for condition	Requires follow-up or referral
a. Chronic chest congestion b. Dysphagia c. Gastroesophageal reflux disorder (GERD) d. Persistent cough e. Pneumonia (in last year) f. Rattling when breathing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

++If diagnoses were not adequately captured or described, provide additional feedback:

++Notes

45. Seizure and 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 (Skip to item d)

b. Indicate all items that apply to the individual

- Currently takes medication to control seizures
- Required a PRN medication (e.g., Ativan or Diastat) in the past year to stop a seizure, two or more times per month, at the time of the seizure
- 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 per 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 (Skip to 46 - Treatments and Therapies)

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 to manage diabetes (Check all that apply)

>>Currently used

- Therapeutic diet

- Exercise
- Blood glucose testing
- Insulin administration
- Other: _____

>>Advisable, but additional support needed to implement

- Therapeutic diet: _____
- Exercise: _____
- Blood glucose testing: _____
- Insulin administration: _____
- Other: _____

>>Advisable, but individual chooses not to implement

- Therapeutic diet: _____
- Exercise: _____
- Blood glucose testing: _____
- Insulin administration: _____
- Other: _____
- No mechanisms advisable

++Notes

46. Treatments and Therapies

a. Is the individual currently receiving, or currently needs, any special treatments or therapies, such as pacemaker, ostomy care, oxygen/respiratory therapy, feeding tube, or dialysis?

- Yes
- No [\[Skip to item 47\]](#)
- Chose not to answer [\[Skip to item 47\]](#)

b. Treatments and Monitoring

Treatment/monitoring/therapy type	Current need [Dropdown:] <ul style="list-style-type: none"> ➤ Has never needed ➤ Does not currently need, but has needed in the past ➤ Needs but does not receive ➤ Receives less than weekly ➤ Receives weekly, fewer than 5 days per week ➤ Receives weekly, 5 or more days per week ➤ Receives daily ➤ Receives 5 or more times per day 	Support person performs	Requires training and oversight from a medical professional	Notes for support planning
Respiratory therapy	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Chest percussion (including percussion vest)	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Postural drainage	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Nebulizer	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheal aerosol therapy	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Oral suctioning that does not extend beyond the oral cavity	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Airway suctioning	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	

Tracheal suctioning	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Nasopharyngeal suctioning	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Other suctioning	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheostomy care	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Care for central line	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Intravenous (IV) injections/infusions	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Subcutaneous injections	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Jejunostomy tube	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube)	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Indwelling or suprapubic catheter monitoring	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
Insertion of catheter (intermittent catheterization)	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	
CPAP/BiPAP	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	

Mechanical ventilator other than CPAP/BiPAP	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Oxygen therapy	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Colostomy, urostomy, and/or other ostomy	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Peritoneal dialysis	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Hemodialysis	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Active cerebral shunt monitoring	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Baclofen pump	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Wound care, excluding stage III or IV ulcers	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Treatment for stage III or IV ulcers (full loss of skin and tissue, may extend into muscle or bone)	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Behavioral health therapies, including mental health	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Psychiatric therapies/services	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Other	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____

Other	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Other	[Dropdown]	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____

++Notes

47. Medication

a. Individual currently takes prescription medications or routine over-the-counter medications recommended by a medical professional (including inhalants/mists, suppositories; oral, injectable, and topical medications; and medicines administered through a tube).

- Yes
- No [[Skip to item i](#)]

b. Does the individual take medication known to cause dehydration?

- Yes
- None that the individual, proxy or assessor is aware of

{Item 47.c is skipped for individuals under the age of 18}

c. Medication management, oral medications - The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 47.d is skipped for individuals under the age of 18}

d. Medication management, inhalant/mist medications - The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 47.e is skipped for individuals under the age of 18}

e. Medication management, injectable medications - The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 47.f is skipped for individuals under the age of 18}

f. Medication management, topical medications - The ability to prepare and apply all prescribed topical medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance

- 03 Partial/moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted due to medical condition or safety concerns

{Item 47.g is skipped for individuals under the age of 18}

g. Medication management, suppository medications - The ability to prepare and apply all prescribed suppository medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial /moderate assistance
- 02 Substantial/maximal assistance
- 01 Dependent

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted

{Item 47.h is skipped for individuals under the age of 18}

h. Medication management, medications through tube - The ability to prepare and apply all prescribed medications that are administered through a feeding tube reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

- 06 Independent
- 05 Setup or clean-up assistance
- 04 Supervision or touching assistance
- 03 Partial

++If activity was not attempted, code reason:

- 07 Person refused
- 09 Not applicable
- 88 Not attempted

i. Other concerns about medications or medication management

++Notes