



State of Connecticut
Department of Developmental Services

DDS

Dannel P. Malloy
Governor

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

**DEPARTMENT OF DEVELOPMENTAL SERVICES TESTIMONY
BEFORE THE PUBLIC HEALTH COMMITTEE**

March 2, 2016

Good morning Senator Gerratana, Representative Ritter, Senator Markley, Representative Srinivasan and members of the Public Health Committee. I am Morna Murray, Commissioner of the Department of Developmental Services (DDS) and I appreciate the opportunity to comment on **S.B. No. 294 AN ACT CONCERNING SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY**.

Section 1 of the bill focuses on concerns that have been expressed by some families regarding communication from DDS on status for funding and services by requiring DDS to share detailed information regularly in writing and in some cases, via certified mail.

First and foremost, I do appreciate the frustration of families regarding a perceived lack of information. The DDS system of supports is large and multi-layered, but the department works extremely hard to do as much as we can for as many individuals and their families as possible within available resources. At the outset, and with great appreciation for families' concerns, we must be cautious about legislation that may inadvertently create unforeseen and unnecessary administrative burdens which could interfere with our staff's ability to focus on services and supports for as many individuals as possible. We must also be cautious about sharing protected health information concerning individuals supported by DDS with those not legally entitled to this information.

I would like to explain the information that DDS does share with individuals and families. There are many processes currently in place that directly address a great number of the issues raised by the proposed legislation. Below please find brief summaries of how this information is distributed for both individuals who receive annualized funding for services and supports, and for those who do not receive annualized funding for services and supports. In addition, please find attached the following forms and notices, referenced throughout this document:

- Sample Level of Need (LON) assessment and LON summary
- Sample person-centered Individual Plan (IP)
- Sample priority status notification
- Sample DDS Termination of Funding Letters (1st, 2nd and final)

For individuals receiving annualized funding for services, individuals and families receive information on an annual basis. A LON assessment is done annually prior to an IP being written for each individual. An IP is done for:

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001
460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov
An Affirmative Action/Equal Opportunity Employer

1. All individuals who receive services or supports through a DDS Home and Community Based Services (HCBS) Waiver,
2. all children in the Behavioral Services Program,
3. all individuals who receive any DDS funded residential supports, including individualized home supports, and
4. individuals who pay directly for residential habilitative services.

There is an annual planning process, in which the individual's planning and support team reviews the individual's LON and IP. The LON reflects the individual's strengths and needs. The LON also includes a record of the individual's annualized funding amount. The IP contains the goals, supports, and services for the individual for the year. The IP also includes a record of the individual's priority status.

Thirty days before the annual meeting, the case manager sends the individual's existing LON to the team. The team then reviews and updates the existing LON. Any changes are communicated to the case manager, who makes said changes and brings an updated LON assessment and LON summary for distribution at the annual meeting. This updated LON is the basis for discussion about the individual's IP at the annual meeting. At this meeting, the individual's team reviews each section of the IP and recommends changes, with a particular focus on any changes in the LON. At the end of the IP meeting, the case manager documents the participants in the planning process and obtains their signatures on a signature sheet. The form states that the individual, parent, guardian or advocate should contact the individual's case manager in writing if they do not agree with the plan as written. The case manager then has 30 days following the meeting to update the IP and send to the individual's team.

For individuals who do not receive annualized funding for services, individuals and families can receive information through the DDS Regional Helpline. Helpline staff are case managers who can provide information on how to apply for limited DDS Family Support Services, or to refer them to appropriate community resources and services. If they make a request for a service and are granted the service, they are assigned a case manager and follow the annual process outlined above. If the individual is denied a service, notification of priority status occurs at that time. These individuals would not have an IP and may have a LON if they have asked for priority status or for the purposes of planning.

I will now address each specific section of the proposed bill. To begin, the definitions in the raised bill are problematic in that they do not directly mirror current definitions in agency policies and procedures. It would be confusing at best to introduce a new version of definitions for some of these common terms within the DDS system. For example, the waiting list that individuals are most familiar with is a residential waiting list. To add in day supports to this conversation would cause unnecessary confusion. DDS does maintain a separate day services waiting list.

As to the requirements proposed in the bill, section 1(b) requires that a copy of the LON assessment be provided to multiple parties including the individual's parent, conservator, guardian or other legal representative. As described above, this information is shared with the individual or the legal guardian on an annual basis for individuals receiving annualized funding for supports and services. Confidentiality of protected health information is a requirement for DDS, as it is for many human service agencies. While many individuals supported by DDS have a legal guardian, not all do. The legislation seems to require that information be shared with multiple persons without addressing whether or not the persons listed are legally entitled to the information. Any requirements that DDS share the type of information outlined in the bill would have to be carefully analyzed so that such requirement would not violate any HIPAA restrictions on the sharing of protected health information.

Section 1 (c) (1) and (2) would require notification of an individual's priority status and the amount of funding budgeted for each service provided by DDS. These provisions are currently in practice at DDS. If an individual has an IP their priority status is listed therein. If there is a change to their priority status, they are also notified in writing, although not by certified mail. Of note, there would be a cost associated with requiring documents to be sent by certified mail which according to the USPS Certified Mail Rates, appears to be \$4.69 per 1-ounce letter. The confidentiality issues noted previously are also applicable to this section.

Section 1(d) focuses on DDS waiting lists, however, as written, it appears the intent of this section is the residential waiting list. Section 1(d)(1) requires an update of the waiting list at least every three years. DDS maintains a **Management Information Report (MIR)** which contains information about the residential needs of individuals, is updated quarterly and is available on the DDS website.

Section 1(d)(2) states that an individual cannot be removed from the waiting list without permission from the individual or other legal representative. This restriction would be unnecessary. If funding is allocated and the individual's needs are met, the individual is considered "placed" in the Planning and Resource Allocation Team (PRAT) database, once services begin. An individual can become activated on the Other Residential Needs List (ORN) at any time the individual has a new unmet need.

Section 1(d)(3) requires a written request to the Commissioner in order to remove an individual's name from the waiting list. The request must include a clear acknowledgement of the consequences of removing the individual's name. Removal from the residential waiting list occurs only if (1) an individual's residential needs are fully met, or (2) if an individual's residential needs are partially met through an allocation of more than \$20,000 at which time they are moved to the ORN List. Individuals on the ORN list still have a prioritization as Emergency or Priority 1 for the additional supports that they need. In FY15, DDS successfully met the needs of 134 individuals (33 Emergency and 101 Priority 1) who were on the ORN list.

DDS understands that the current waiting list definitions may be confusing. In an effort to address this, DDS initiated a project to review current residential waiting list and planning list definitions in order to ensure that the criteria and data is clear to all stakeholders. The Arc-CT and a family representative have been invited to participate with DDS on this project. The current residential needs data as of December 31, 2015 is as follows:

Residential Waiting List: 18 Emergency and 645 Priority 1 for a total of 663
Other Residential Needs List: 14 Emergency and 254 Priority 1 for a total of 268
Residential Planning List: 883 Priority 2 and 265 Priority 3 for a total of 1148

In FY 2015, 163 individuals came off the residential waiting list including 83 with funding from the waiting list initiative for individuals with elderly caregivers and 80 who did not receive funding from this initiative. To date, 117 individuals have begun residential supports and five additional individuals have plans to start this fiscal year (FY16), with funding from the waiting list initiative for individuals with elderly caregivers.

Section 1(e) of the bill requires that whenever funding for services is offered, it must be done in writing with notice of an explicit deadline for acceptance or rejection of said funding, and an explanation of the consequences of accepting or rejecting such offer including the individual's right to receive additional services or maintain his or her place on the waiting list. DDS has concerns about the administration of this provision and its potential unintended consequences for families. Establishing hard deadlines would likely limit flexibility and creativity of individuals, families, and providers in developing supports within

the person-centered system of planning that DDS utilizes. DDS looks at how to best meet the individualized needs as part of person-centered planning. There are multiple choices available to individuals including the choice of residential services, choice of provider, timing of services, etc. All these decisions affect what funding may be required for these individualized services and when the funding is needed. DDS believes that creating appropriate services and supports for individuals within this highly individualized and person-centered model requires fluidity and flexibility to maintain the focus on what is best for each individual.

As stated previously, DDS is a complex and multi-layered system. But ultimately, we are all working toward the same goals as individuals, family members, guardians, providers, advocates and other stakeholders, to ensure that the best supports and services are provided to as many individuals with intellectual disability as possible. We truly value the important role that all stakeholders have in each aspect of service delivery and DDS will continue to work on improving consistency in the various avenues of communication available to us. We caution legislators not to impose unrealistic or unnecessary administrative burdens on the department that could unintentionally hinder the important work that we are all trying to accomplish.

Section 2 of the bill would replace language from Section 23 of Public Act 15-1 of the December Special Session, and requires outreach to stakeholders for the report on a plan to implement the closure of facilities operated by DDS. This provision is not necessary since the Office of Policy and Management intends to consult with stakeholders.

The purpose of section 3 is unclear as written. Section 17a-218(g) of the Connecticut General Statutes already requires “any person who is in or is seeking a placement through the Department of Developmental Services or is receiving any support or service that is included within or covered by any federal program being administered and operated by the Department of Social Services and the Department of Developmental Services, and who meets the eligibility criteria for the federal program, shall enroll in such program in order to continue in the existing placement or to remain eligible for a placement or continue to receive such support or service.” DDS works closely with Department of Social Services (DSS) staff regarding Medicaid eligibility and redeterminations. Three DSS staff are located within DDS’s central office and are specifically dedicated to assisting DDS staff, individuals and providers with initial eligibility, waiver enrollment, redeterminations, and special projects. These DSS staff act as liaisons with DDS central and regional offices to resolve specific Medicaid issues or any problems that DDS consumers may have.

Specific notices (see attached 1st, 2nd and final notice) are given to individuals and families who are not compliant with section 17a-218(g) CGS. Failure to comply with the request to contact the case manager and complete the waiver enrollment process results in a case review which may lead to termination of DDS funding for supports and services. Non-compliance with waiver requirements on the part of some individuals is not fair to the number of people waiting for funding for services. With the final notice indicating that termination of supports will occur, individuals are notified of the right to appeal the decision through the Fair Hearing Process at DSS. Finally, it would not be appropriate for DDS to assist in the identification and securing of private funding for care or services for someone who has not complied with Section 17a-218(g) CGS.

Thank you again for the opportunity to testify on **S.B. No. 294**. I would be happy to answer any questions you have at this time. You may also contact Christine Pollio Cooney, DDS Director of Legislative and Executive Affairs at (860) 418-6066 with additional questions.



CT DMR Level of Need Assessment and Screening Tool

Date: 12/11/2013

Region: SR

Date of birth: [REDACTED]

First name [REDACTED]

MI [REDACTED]

Last name [REDACTED]

DDS number [REDACTED]

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

Health and Medical

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

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

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

Support Provider – Who typically provides this support:

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

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

11. If the family member as primary provider is not available for any of the above treatments, is this care then provided by a medically licensed support provider (for example, by an RN, LPN, respiratory therapist or physical therapist)?

- No
- Yes
- Not applicable - Above care not provided by a family member or not needed

12. Does the person require any hands on or direct care from a nurse (LPN or RN) to provide routine care? This does not include routine examinations or assessments, such as blood pressure checks, incident monitoring, monthly assessments, etc.

- No → If No, Skip to Question 14
- Yes

13a. How often is this hands on or direct care from a nurse (RN or LPN) currently needed?

- 1 - 5 times a year
- 2 - 3 times a month
- 4 - 6 times a week
- 6 - 11 times a year
- Once a week
- At least once a day
- Once a month
- 2 - 3 times a week

13b. If daily hands on or direct care from an LPN/RN is needed, how much LPN/RN care is needed?

- Direct nursing care is not needed every day
- 16 to less than 24 hours a day
- Less than 8 hours a day
- Continuous, 24 hour direct nursing care required
- 8 to less than 16 hours a day
- If continuous nursing care needed, provide explanation in box at end of health section.*

14. In the past year, how often did the person have a grand mal or convulsive seizure? Note: Other types of seizure activity are asked about in question 16.

- None in past year
- Once a month
- Several times a week or more
- Less than once a month
- Several times a month or weekly
- N/A - Has never had a seizure

15. Check all the developmental disability diagnoses that apply:

- Mental retardation
- Cerebral palsy
- Down Syndrome
- Prader Willi
- Other chromosomal disorder (Fragile X, Klinefelter's Syndrome, etc.)
- Autism, Asperger's Syndrome, or pervasive developmental disorder
- Brain injury (TBI, ABI)
- Spina bifida
- Fetal alcohol syndrome
- Other neurological impairment (includes meningitis, hydrocephalus, etc.)
- Other: brain hemorrhage as a newborn

16. Check all diagnosed health conditions:

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

17. Check all of the following which currently apply:

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

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

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

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

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

20. If person is currently hospitalized (medical or psychiatric) or in a rehabilitation facility:

- a. Is a written discharge plan in place?
 - Yes
 - No
 - Person is not in a hospital/rehab facility
- b. Anticipated date of discharge: _____

21. Please check all that apply regarding medications:

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

Comments about health and medical:

Personal Care Activities

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

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

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

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

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

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

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

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

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

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

Comments about personal care

Daily Living Activities

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

- 31. Mobility in the community – includes the ability to move around outside and in the community. *Does not include any transportation needs.*
 - Walks by self with or without assistive devices, such as a brace, walker, cane, prosthesis, etc.
 - Walks by self, but may require physical support or assistance from another person.
 - Does not walk. Uses wheelchair or scooter independently to get around.
 - Does not walk. Uses wheelchair with assistance from another person (such as to push wheelchair).
- 32. Taking medications – includes taking the correct medication and dose at the correct time or filling pillbox if used. Includes monitoring glucose level if needed.
 - Takes medications correctly by self (correct medication, correct dose, correct time). May use assistive devices such as a pillbox, etc.
 - Takes medications with monitoring, prompting, or reminders, or may need assistance to set up a weekly or daily pillbox.
 - Requires assistance to take medications, such as to prepare or administer the medication.
 - Does not take medications.
- 33. Using the telephone – includes dialing the number and/or communicating over the phone.
 - Uses the telephone independently. May use assistive devices to dial or communicate over the phone (such as programmed dialing, TTY, etc.).
 - Uses telephone with prompting, instruction, or encouragement. May need assistance with dialing numbers.
 - Always requires assistance to use telephone or TTY, or cannot use telephone at all.
- 34. Doing household chores – includes housecleaning, laundry, etc.
 - Does household chores by self independently. May use assistive devices.
 - Does household chores with prompting, monitoring, instruction, or encouragement.
 - Requires assistance to complete household chores, or cannot complete household chores at all.
- 35. Shopping and meal planning – includes planning for meals and shopping for groceries or other goods in neighborhood area. *Does not include any transportation required.*
 - Plans for meals and shops for groceries, etc., in neighborhood stores independently. Excludes any transportation. May use assistive devices.
 - Plans for meals and shops in neighborhood stores with prompting, monitoring, or instruction. Excludes any transportation.
 - Requires assistance for meal planning and shopping, such as someone to make the grocery list or pay the cashier; or cannot do any part of shopping and meal planning at all. Excludes any transportation.
- 36. Meal preparation and cooking – includes getting the food out of the cupboard or refrigerator, preparing food (including making food into appropriate consistency such as ground up, specified piece size, pureed, or liquefied), making cold meals (such as sandwiches or snacks), and cooking simple meals.
 - Prepares and cooks food independently using either microwave or stove. May use assistive devices. Can make cold foods (sandwiches, snacks) or simple meals.
 - Prepares and cooks food such as sandwiches and simple meals with prompting, monitoring, or instruction. Can safely use a microwave with instructions, prompting, or monitoring.
 - Requires assistance to prepare and cook food. Cannot use either microwave or stove.
- 37. Budgeting and money management – includes being able to budget for expenses within a set income and pay bills.
 - Budgets, pays bills, and manages own money independently. May use assistive devices.
 - Budgets, pays bills, and manages money with prompting, monitoring, or instruction.
 - Requires assistance to budget, pay bills, or manage money, or cannot budget or manage money at all.
- 38. Transitioning – includes being able to discontinue one activity or task and begin another, including activities at home, school, work, vocational or day program, and leisure or recreational activities.
 - Transitions from or to activities or tasks by self independently.
 - Transitions to or from an activity with prompting, monitoring, instruction, or encouragement.
 - Requires assistance in order to transition from one activity to another.

Comments about daily living activities:

Behavioral and Mental Health

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

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

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

At Home or Residence

At Day, School, Job, or Vocational Program

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

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

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

Psychiatric or mental health condition

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

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

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

Current status (past 3 – 6 months)

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

Psychiatric or mental health condition (include formal diagnosis by mental health clinician)	At Home or Residence				At Day, School, Job, or Vocational Program			
	Yes	No	Support Type	Current Status	Yes	No	Support Type	Current Status
56. Diagnosed psychotic disorder – Includes schizophrenia, psychosis, schizoaffective disorder, etc. Write in formal diagnosis:	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>
57a. Diagnosed mood disorder – includes bipolar disorder, major depression, depressive disorder, etc. Write in formal diagnosis:	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>
57b. Other diagnosed psychiatric or mental health condition – Write in formal diagnosis:	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>	<input type="text"/>

58. Does the person require a greater level of support due to behavioral or mental health concerns when out in the community?

- No
- Yes – please describe in behavioral, mental, or emotional health comments box

Comments about behavioral or mental health concerns?

Safety

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

Not applicable

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

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

Comments about safety:

Waking hours level of support

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

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

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

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

No support required:

- Person is competitively employed or is independent during the day

Periodic support required:

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

Support required for the entire time:

- Larger group support (one staff person for 4 or more people)
- Small group support (one staff person for 2 – 3 people)
- One to one support due to personal support needs
- More than one person support due to personal support needs

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

Home or Residence Level of Support – Waking Hours

81. Frequency of support, monitoring, or assistance – How often does this person typically need support during waking hours at his/her home or residence? Please check only one.

- Less than monthly
- 1 to 3 times a month
- Once a week
- Several times a week
- Once a day
- Multiple times a day
- Continuous support needed during waking hours
- Person can never be left alone in a room and must always be in constant line of sight
- Person can never be left alone in a room and must always be within arms length
- No support needed

82. Level of support, monitoring, or assistance – What level of support does this person typically need during waking hours at his/her home or residence? Please check only one.

- On-call support only
- Periodic in-person support
- Lives in family home and needs support always available
- Larger group support (one person for 4 or more people)
- Small group support (one person for 2 – 3 people)
- One to one support only, either at arms length or in constant line of sight
- More than one person typically needed
- No support is needed

83. During the day, how many hours at one time can this person typically be safely left alone in the house or residence at one time, with no other adults at home? 0 _____ Hours

Overnight support, monitoring, or assistance

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

85. Does the person require any of the following during overnight or when sleeping? Check all that apply.

- Bed alarm
- Vail or enclosed bed
- Door alarm
- Refrigerator lock or alarm
- Other environmental monitoring or alarm (list): _____
- None

Comments about Overnight support, monitoring, or assistance:

Comprehension and Understanding

- | | <u>Yes</u> | <u>No</u> |
|---|----------------------------------|----------------------------------|
| 86. Can the person understand simple instructions or questions (for example, "Did you like your dinner?" or "Raise your arms")? | <input checked="" type="radio"/> | <input type="radio"/> |
| 87. Can the person understand complex instructions or questions with two different parts (for example, "Do you need eggs from the grocery store?" or "Please put on your coat, and take these letters to the mailbox")? | <input type="radio"/> | <input checked="" type="radio"/> |
| 88. If the person is age 18 or older, can the person read at the 5 th grade level (for example, can the person read the local newspaper)? | <input type="radio"/> | <input checked="" type="radio"/> |

Is under age 18

Communication

89. Please check the one description which best describes the person's ability to communicate.
- Verbal communication with little or no difficulty, both expressing (sending) and receiving language.
 - Verbal communication with some difficulty or limited skills with either expressing or receiving messages.
 - Severely limited verbal (cannot easily form words), or is basically nonverbal. Usually uses alternative method of communicating such as manual or sign language, written words, pictures, electronic systems, communication board, gesturing or pointing, etc.
 - Nonverbal with severe communication difficulties. Little or no expressive communication but may use some non-verbal communication skills such as eye gazing, or facial expressions. Does not use any alternative communication devices.
 - Unable to communicate
90. Does the person follow social rules of conversation appropriately, in different situations and with different listeners? This includes taking turns when speaking, using appropriate language, and using an appropriate tone of voice.
- Always or most of the time
 - Some of the time
 - Rarely
 - Never
91. Does the person speak English? Please check one.
- Yes (or enough that no interpreter is needed)
 - No – person needs a foreign language interpreter
 - No – person needs an interpreter for the deaf
 - Not applicable – person uses alternative communication system or cannot communicate

Comments about comprehension or communication:

Transportation

92. How does the person usually get to places out of walking distance? Check all that apply:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Uses a provider's van or vehicle | <input type="checkbox"/> Uses taxi service |
| <input checked="" type="checkbox"/> Gets ride from staff in staff person's car | <input type="checkbox"/> Drives self |
| <input type="checkbox"/> Uses public transportation such as city bus | <input checked="" type="checkbox"/> School bus |
| <input checked="" type="checkbox"/> Gets a ride from a family member or friend | <input type="checkbox"/> Other: _____ |
| <input checked="" type="checkbox"/> Uses para-transit, dial a ride, or handicapped van | |

93. Does the person require a van with a lift?

- Yes
- No

94. Does the person require vehicle modifications to travel safely? This may include grab bars, seat belt extenders, or wheelchair tie downs.

- Yes - please explain: tie downs _____
- No

95. Does the person require support for his/her behaviors or for health reasons from other person(s) in addition to the driver while in a vehicle?

- Yes - please explain: _____
- No

96. How much support does this person require to arrange or schedule his/her own transportation? This may include looking up van or bus schedule, calling for ride, canceling ride if not needed, obtaining bus route or driving directions, or taking public transportation. Check only one box.

- Able to arrange or schedule own transportation independently. This may include independently arranging for a van ride or using public transportation after initial instruction. Includes people who are able to drive. May use assistive devices, such as a phone amplifier, speed dialing, etc.
- Able to arrange or schedule own transportation with prompting, monitoring, or instruction. May need help dialing phone or looking up bus/van schedule. Uses public transportation only with prompting or regular instruction.
- Cannot arrange or schedule transportation at all.

Social Life, Recreation, and Community Activities

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

97. Establishes and maintains friendships and supportive relationships – includes making friends and getting in touch with them, by either calling, emailing, in-person at events, work, etc. Excludes any transportation or mobility assistance needed.

- Able to establish and maintain friendships independently. May use assistive devices.
- Able to establish and maintain friendships only with prompting, encouragement, or social coaching.
- Requires assistance to establish and maintain friendships, such as social training or help with dialing a number or signing up for an event.

98. Takes part in leisure activities, hobbies, or recreation in his/her home or residence – includes any leisure activities done at home, such as TV, music, reading, puzzles, etc. Excludes any mobility assistance needed.

- Able to independently take part in leisure activities at home. May use assistive devices.
- Able to take part in leisure activities at home only with encouragement, prompting, or monitoring. May need some initial assistance with getting a game out, putting in a video, etc.
- Requires continual assistance to take part in leisure activities, hobbies, or recreation at home.

99. Takes part in activities in the community for recreation and enjoyment – includes movies, church, bowling, Special Olympics, dances, etc. Excludes any transportation or mobility assistance needed.

- Able to independently take part in activities in the community for recreation and enjoyment. May use assistive devices.
- Able to take part in activities in the community for recreation and enjoyment only with monitoring, prompting, or encouragement. May need some initial assistance with making plans, signing up for an event, etc.
- Requires continual assistance to take part in community activities for recreation and enjoyment.

100. How often does the person typically take part in activities in the community for recreation or enjoyment?

- Once a week or more
- Once or twice a month
- One to eleven times a year
- Never

101. What prevents the person from taking part in more activities in the community for recreation and enjoyment? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Low motivation or interest | <input checked="" type="checkbox"/> No one available to accompany the person |
| <input type="checkbox"/> Behavioral or emotional concerns | <input type="checkbox"/> Lack of available recreation activities |
| <input type="checkbox"/> Social skills limitations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Health concerns | <input type="checkbox"/> Nothing prevents person – He/she is happy with current amount of recreation activities |
| <input checked="" type="checkbox"/> Money or cost concerns | |
| <input checked="" type="checkbox"/> Inadequate transportation | |

102. Does this person typically take part in educational opportunities in their community, such as adult education, night school, or community college?

- Yes, at least once a year
- Yes, but not in the past year
- No

Comments about transportation or social or community activities:

Person's Own Caregiving Responsibilities

103. Is this person a primary caregiver for another person?

No

Yes → What is his/her relationship to the person he/she is taking care of? _____

Person's Own Parental Responsibilities

This section concerns any parental responsibilities the person has themselves.

104. Does this person have any children?

No → If No, Skip to Question 106

Yes

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

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

Primary Caregiver Support (Unpaid)

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

106. Is this person his or her own primary caregiver?
 Yes → Skip to Question 111
 No
107. Does this person have an unpaid primary caregiver?
 No → Skip to Question 111
 Yes
108. How is the primary caregiver related to this person? Check only one.
 Person's spouse or unmarried partner Sibling CTH provider
 Parent Grandparent Other: _____
109. How is the secondary caregiver related to this person? Check only one.
 Person has no secondary caregiver Sibling Spouse or partner of primary
 Person's spouse or unmarried partner Grandparent caregiver
 Parent CTH provider Other: _____
110. Check the box in the first column if any of the following apply to the primary unpaid caregiver. Information may be obtained from the caregiver, other team or support staff members, or the person's record. Check any in the second column that apply to the secondary unpaid caregiver (such as when two caregiving parents). If no secondary caregiver, leave the second column blank. Do not include any paid caregiving support. Check all that apply.

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

Other Unpaid Supports

111. Does the person have any other people who provide unpaid regular support or assistance at least once a month? This does not include anyone providing paid support or assistance. Check all that apply.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Person has no regular, unpaid natural supports | <input type="checkbox"/> Co-worker |
| <input type="checkbox"/> Parent or sibling | <input type="checkbox"/> Neighbor/Member of his/hier religious organization |
| <input type="checkbox"/> Other family member: _____ | <input type="checkbox"/> Unrelated guardian, conservator, or legal advocate |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Roommate | |

Comments about unpaid caregiving supports:

Any other concerns

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

Current Budget and Pending Service Requests

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

- No
- Yes
- I don't know

113b. If Yes, please indicate: What is his/her current individual budget? \$ 35,102
 What is his/her current day budget? \$ 0
 What is his/her residential budget? \$ 35,102

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

- No
- Yes

Information about person(s) filling out this form

Name of person filling out form:	Relationship to the individual:	Work / Day Number:	Date completed:
	DDS Case Manager		12/11/13
	parent		12/11/13
	parent		12/11/13
	self		12/11/13
	ARC of M/W		12/11/13

The development of this assessment tool has been sponsored in part through an *Independence Plus* Systems Change Grant (11-P-92079/1-01) funded by the Centers for Medicare and Medicaid Services.

Copyright 2006, Connecticut Department of Mental Retardation. All rights reserved. No part of this publication may be reproduced without written permission by the Connecticut Department of Mental Retardation

Connecticut DDS Level of Need Assessment and Screening Tool Summary Report (PRAT)

Name: [REDACTED] Date of Birth: [REDACTED] DDS [REDACTED] Date of Assessment: 12/11/2013 Region: SR

Assessment Summary:

Section	0	1	2	3	4	5	6	7	8
Health and Medical(Home/Res)			X						
Health and Medical(Day/Voc/School)			X						
PICA (Home/Res)	X								
PICA (Day/Voc/School)	X								
Behavior (Home/Res)	X								
Behavior (Day/Voc/School)	X								
Psychiatric (Home/Res)	X								
Psychiatric (Day/Voc/School)	X								
Criminal/Sexual Issues (Home/Res)	X								
Criminal/Sexual Issues (Day/Voc/School)	X								
Seizure	X								
Mobility								X	
Safety						X			
Comprehension and Understanding			X						
Social Life							X		
Communication				X					
Personal Care							X		
Daily Living							X		

Connecticut DDS Level of Need Assessment and Screening Tool Summary Report (PRAT)

Name: [REDACTED]

Date of Birth: [REDACTED]

DMR # [REDACTED]

Date of Assessment: 12/11/2013 Region: SR

Assessment Domains:

Health and Medical

Oxygen (q4)	
Tube Feeding (q9)	
Smoke (q17)	
Grand Mal or Convulsive Seizure (14)	
Auto Immune Disease (q16)	
Cancer (q16)	
Chronic Constipation/Diarrhea (q16)	
Dementia or Alzheimer's Disease (q16)	
Dental or Gum Disease (q16)	
Diabetes (oral meds required) (q16)	
Diabetes (injected meds required) (q16)	
Dysphagia (swallowing disorder) (q16)	
Heart Condition (q16)	
High Blood Pressure (q16)	
Kidney Disease (requiring dialysis) (q16)	
Parkinson's Disease (q16)	
Pregnancy (q16)	
Pulmonary Condition (q16)	
Severe Allergy or Allergic Reaction (q16)	
Sleep Apnea (q16)	
Stroke or CVA (q16)	

Substance Abuse (current) (q16)	
Substance Abuse (history of) (q16)	
Weight Issues (over) (q16)	
Weight Issues (under) (q16)	
Two or More Falls in past 3 months (q17)	
<u>Medical Care</u>	
Hands on, direct LPN/RN care (q12)	
Direct LPN/RN (frequency) (q13a)	0
Direct LPN/RN (intensity) (q13b)	
Medically Prescribed Special Diet (q17)	X
Medical Devices (q17)	
Medical Office Visits (q18)	3
<u>Extra Support</u>	
Extra Behavior Support in Community	
Extra Support When Traveling in Car	
<u>Vehicle</u>	
Vehicle Modifications Needed (q94)	X
Van with Lift (q93)	X
<u>Caregiving</u>	
Primary Caregiver Score (q110)	1
Secondary Caregiver Score (q110)	1
Primary Parental Responsibility (q104)	

<u>Medical Care</u>	
Heart Medications/Blood Thinners (q21)	
Frequently Changes in Medication (q21)	
Long Term Use of Meds (q21)	
<u>Diagnosis</u>	
Down Syndrome (q15)	
Other Chromosomal Disorder (q15)	
Psychotic Disorder (q56)	
Mood or Personality Disorder (q57)	
<u>Risks</u>	
Refusal of Critical Services (q74)	
Homeless or Risk of Homelessness	
<u>Incidents in Past 12 Months</u>	
Emergency Hospitalization (q77)	
Unusual Incident or Behavior (q77)	
Suicide Attempt or Gesture (q77)	
<u>Other</u>	
Person is non-English Speaking (q91)	0
Overnight Support (q84)	2
Home Modifications (q73)	

The higher the result in each area, relative to the maximum, the more likely the person requires an increasing level of support. Those support needs should be considered in the development of the Individual Plan when planning for the achievement of desired personal outcomes.

Connecticut DDS Level of Need Assessment and Screening Tool Summary Report (PRAT)

Name: [Redacted] Date of Birth: [Redacted] Date of Assessment: 12/11/2013 Region: SR
 DDS #: [Redacted]

Potential Risk: The following areas were identified in this assessment and screening as having the potential for risk and must be addressed in the person's Individual Plan. This may include the identification of a needed assessment or evaluation, and associated step in the action plan to obtain that assessment or evaluation; reference that current supports, guidelines, or a protocol are in place to address the need; specific notation of the team's review in the personal profile of the plan, or recommendations if any for additional supports, training, or sharing of information.

Area of Support	Strategies to Address Identified Risk:	Other	Natural Supports	Clinical Services	Nursing Care Plan	Professional Assessment	Periodic Monitoring	Self/Staff Training	Written Guidelines or Protocols	Enhanced Staffing	Staffing/ Supervision supports	Fact Sheets Educational Materials
Health and Medical	*Requires food or liquid to be in particular consistency or size											
	Medication/s require careful monitoring for side effects											
Personal Care	*Requires hands on assistance for bathing or showering.											
	Requires hands on assistance with putting food on utensil or requires hand over hand feeding.											
	*Does not walk. Uses wheelchair with assistance from another person.											
	*Requires hands on assistance to change position in bed/chair.											
Safety	Unable to avoid being taken advantage of financially											
	Unable to avoid being taken advantage of sexually											
	Unable to avoid being taken advantage of electronically, internet											
Other	Vehicle modifications											

Connecticut DDS Level of Need Assessment and Screening Tool Summary Report (PRAT)

Name: [REDACTED] Date of Birth: [REDACTED] DDS #: [REDACTED] Date of Assessment: 12/11/2013 Region: SR

Assessment Summary:

Section	0	1	2	3	4	5	6	7	8
Composite Score (Home/Res)								X	
Composite Score (Day/Voc/School)								X	

Current Individual Budgets: Day: \$0.00: Residential: \$0.00: Combined: \$0.00:
 New Resource Allocation: Day: \$0.00: Residential: \$0.00: Combined: \$0.00:
 Additional Domains: \$0.00:

Persons Who Contributed to the Assessment:

Name	Relationship
[REDACTED]	DDS Case Manager
[REDACTED]	parent
[REDACTED]	parent
[REDACTED]	self
[REDACTED]	ARC of MW

* denotes CAMRIS update required



IP.1 - Information Profile

Name:	Date:	
Address:	Sex: Select	
City/Zip: ,	DOB:	
Phone: () -	DDS#:	
Type of Residence: Select	Primary language: English	Ethnicity: Select
Allergies:	Communication Style: Select	

Case Manager (CM):	CM Phone: () -	
Level of MR: Select	Diagnosis:	ICD 9 codes:
Legal Status: Select	Type of Waiver: Select	
Registered Voter: Select	Waiver Enrollment Date:	
Residential WL: <input type="checkbox"/> Priority Status:	Day WL: <input type="checkbox"/> Priority Status:	
WL Referral Date:	WL Referral Date:	

Guardian: Select		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	
Primary Responsible Person		
Name:	Home: () -	Cell: () -
Relationship:	Email: @ .	
Address:		
Emergency Contact (stand by if PRP is not available)		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	
Conservator		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	

Medical Contacts:

Physician:	Phone: () -	Fax: () -
Dentist:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -

Provider Agency Contacts		
Residential:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
Day:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
Fiscal Intermediary:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
DSS:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
SSI:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	



Other:	Phone: () -	Fax: () -
Contact/Title: ,		Email: @ .
Other:	Phone: () -	Fax: () -
Contact/Title: ,		Email: @ .

Resource and Benefit information (Check all that apply)

Medicaid Application/Redetermination Current <input type="checkbox"/> Yes Last Redetermination Date: / /		
<input type="checkbox"/> Earned Income – Monthly \$	<input type="checkbox"/> Prepaid Funeral Plan	<input type="checkbox"/> Health Insurance#
<input type="checkbox"/> Savings Balance \$	<input type="checkbox"/> Prepaid Burial Plan	<input type="checkbox"/> Railroad Insurance#
<input type="checkbox"/> SSI# - - Month \$	<input type="checkbox"/> Title XIX #	<input type="checkbox"/> Medicare A#
<input type="checkbox"/> SSDI# Monthly \$	<input type="checkbox"/> DSS Cash Assistance \$	<input type="checkbox"/> Medicare B#
<input type="checkbox"/> Checking Balance \$	<input type="checkbox"/> Food Stamps Monthly\$	<input type="checkbox"/> Medicare D#
<input type="checkbox"/> Trust Fund \$	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

DDS Support Information

<input type="checkbox"/> CM	<input type="checkbox"/> TCM				
<input type="checkbox"/> Residential	<input type="checkbox"/> Self Direct	<input type="checkbox"/> Vendor	<input type="checkbox"/> Master Contract	<input type="checkbox"/> Public	<input type="checkbox"/> Other
<input type="checkbox"/> Day/Employment	<input type="checkbox"/> Self Direct	<input type="checkbox"/> Vendor	<input type="checkbox"/> Master Contract	<input type="checkbox"/> Public	<input type="checkbox"/> Other
<input type="checkbox"/> Individual and Family Grant	Need Level: <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High			Amount grant amount only	
<input type="checkbox"/> Respite Center	<input type="checkbox"/> Rent Subsidy Monthly:				
<input type="checkbox"/> IFS Resource Support Team	<input type="checkbox"/> Other				

Notifications and Review (Check NA for any that do not apply)

PAR Notification (annually at IP)		Date:
Medicaid Due Process Rights Notification (annually at IP)	<input type="checkbox"/> NA	Date:
Family/Guardian Notification of Incident Reporting Requirements (annually at IP)		Date:
Family/Guardian's Incident Reporting Request, Describe if beyond procedural requirements:		
Individual Informed of Human/Civil Rights (annually at IP)		Date:
Individual Informed of Abuse & Neglect Information (annually at IP)		Date:
Choice of Service Options Discussed (self-directed, vendor, agency with choice) (annually at IP)		Date:
Choice of Independent broker to provide FICS (prior to IP for those who self direct)	<input type="checkbox"/> NA	Date:
Choice of Vendors/Providers discussed		Date:
Waiting list Priority Status Notification (annually at IP for those on WL)	<input type="checkbox"/> NA	Date:
Transfer Hearing Notification	<input type="checkbox"/> NA	Date:
Consent Form(s) (at initial visit or if not current)	<input type="checkbox"/> NA	Date:
HIPAA Notification (at initial visit or if not current)	<input type="checkbox"/> NA	Date:
Legal Liability Notification (at initial visit or change of Guardian)	<input type="checkbox"/> NA	Date:
Voter Registration Notification (at initial visit, IP, after 17 th birthday or new address)	<input type="checkbox"/> NA	Date:
PRC Review (Programmatic Review Committee) month/yr next review, Review exemption annually	<input type="checkbox"/> NA	Date:
Emergency Fact Sheet and Relocation Form Updated, if applicable.	<input type="checkbox"/> Residence <input type="checkbox"/> Day <input type="checkbox"/> NA	Date:
Other Notification:		Date:
Other Notification:		Date:



Name:	DDS#:
Case Manager:	Region: Select
Meeting Date:	Plan Effective Date: to

IP.2 - Personal Profile

For each profile domain, briefly describe the person's current situation, experiences and issues that will be addressed in the development of the individual plan. Please refer to interview prompt questions for each domain. Include choices, preferences, likes and dislikes, as well as, assistance needed to make decisions in relevant domains.

Important To Know About You:

Accomplishments, Strengths and Things You Are Most Proud Of:



Name:	DDS#:
-------	-------

Relationships:

Home Life:



Name:	DDS#:
-------	-------

Work, Day, Retirement or School:

Leisure Interests and Community Life:

Health and Wellness:



Name:	DDS#:
-------	-------

Medications:

List Current medications including Over the Counter (OTC) medications.

Type:	Reason for Medication/Comments:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.

Adaptive Devices (if applicable):

Finances:



Name:	DDS#:
-------	-------

IP.3 - Future Vision

What are your hopes and dreams for the future (one to three years?)

What do you hope to accomplish in the coming year?



Name:	DDS#:
-------	-------

IP.4 Assessments, Screenings, Evaluations and Reports

What current assessment, screenings, evaluations or reports information is available to help you plan for your future?
Indicate if assessments, screenings, evaluations or reports are current, needed or not applicable.

Assessments, Screenings, Evaluation Report:	Current	Needed	N/A
▪ Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Self-Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Gynecological Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other Health/Medical:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Level of Need Assessment & Screening Tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ My Health and Safety Screening (Optional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Speech & Language /Communications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Nutrition/Dietary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other Clinical:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ ADL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Aquatic Activity Screening (Required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Bed & Safety Rail Audit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Vocational/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Guardianship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Resource/Financial (ex. Benefit Checkup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Level of Support and Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Waiting List Priority Checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Respite Profile Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS Nursing Health and Safety Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS DDS Life Skills Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS Self Medication Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Aging Assessments (Falls, Dementia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Name:	DDS#
--------------	-------------

IP.5 - Action Plan

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
1.	1.	1A:		
		1B:		
		1C:		
		1D:		
		1E:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
2.	2.	2A:		
		2B:		
		2C:		
		2D:		
		2E:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
3.	3.	3A:		
		3B:		
		3C:		
		3D:		
		3E:		



Name:	DDS#
--------------	-------------

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
4.	4.	4A:		
		4B:		
		4C:		
		4D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
5.	5.	5A:		
		5B:		
		5C:		
		5D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
6.	6.	6A:		
		6B:		
		6C:		
		6D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Action and Steps	Responsible Person(s)	By When
7.	7.	7A:		
		7B:		
		7C:		
		7D:		



Name:	DDS#
-------	------

IP.7 – Provider Qualifications & Training

DDS Waiver Services to be Provided (please check all that apply):

<input type="checkbox"/> Comp – Individualized Home Support	<input type="checkbox"/> Group Day Supports (includes DSO)
<input type="checkbox"/> Comp – Residential Habilitation (CLA & CTH)	<input type="checkbox"/> Individualized Day Supports
<input type="checkbox"/> Comp – Assisted Living	<input type="checkbox"/> Supported Employment - Individual
<input type="checkbox"/> IFS – Individualized Home Support	<input type="checkbox"/> Supported Employment - Group
<input type="checkbox"/> IFS – Residential Habilitation (CTH)	<input type="checkbox"/> Adult Day Health Services
<input type="checkbox"/> IFS – Family Training	<input type="checkbox"/> Respite
<input type="checkbox"/> Personal Support	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Adult Companion Services	<input type="checkbox"/> Interpreter Services
<input type="checkbox"/> Health Care Coordination	<input type="checkbox"/> Transportation
<input type="checkbox"/> Clinical Behavioral Support Services	<input type="checkbox"/> Independent Support Broker

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>



DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>



Name:	DDS#
-------	------

IP.8 - Emergency Back-Up Plan

This form is to be completed for individuals who receive waiver services and live in their own home, family home or other settings where staff might not be continuously available, and who receive *personal care and/or supervision supports* and the failure of those supports to be available would lead to an immediate risk to the individual's health and/or safety.

- No Emergency Back-up Support Plan is Required
- Yes, an Emergency Back-up Support Plan is Required and Described Below:

Type of Personal Care or Supervision Support Provided	Agency (A) or Self-Directed (SD) Supports		Name of Emergency Contact Person	Telephone Number of Emergency Contact Person	Specific Protocols
	A	SD			
	<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"/>			



Name:

DDS#:

IP.9 - Summary of Representation, Participation & Plan Monitoring

Choice and Decision Making

Planning and Support Team review an assessment of a person's understanding and capacity to make important decisions/choices, accept assistance from others and possible need for guardian/advocate/legal or personal representative.

Individual's Participation in Planning Process

Summary of team's efforts to involve the person in planning, the person's actual participation in the planning process, and planned efforts to enhance the person's future participation in planning.

Representative's Participation in Planning Process

Summary of the team's efforts to involve the person's family/guardian/advocate/legal or personal representative in the planning process, the actual participation of these individuals in the process, and planned efforts to involve these individuals in planning in the future.

Summary of Monitoring and Evaluation of the Plan

Summary of the team's efforts to ensure that the plan is being implemented and that progress is being made toward desired outcomes.



Name:	Region: Select	DDS#
Case Manager:	Plan Date:	

IP.10 – HCBS Re-determination

There is a reasonable indication that the person, but for the provision of waiver services would need services in an ICF/MR or NF. [42CFR441.302(c)]

The person requires assistance due to the following (check at least one):

- Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily activities
- Has a deficit in self-care and daily living skills requiring habilitative training
- Has a maladaptive social and/or interpersonal behavior patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training

This determination was made through a planning and support team process based on comprehensive professional assessments, evaluations, and/or reports that are on file in the:

- Case Record; or
- Other Location (identify)"

Signature: _____

Title (QMRP):



Name:	DDS#	Meeting Date:	<input type="checkbox"/> Plan Development
			<input type="checkbox"/> Periodic Review
			<input type="checkbox"/> Other

IP.11 - Individual Plan Signature Sheet

Name	Signature	Relationship To The Person	Attended Meeting (x)
		Individual	<input type="checkbox"/>
		Family Member/Guardian	<input type="checkbox"/>
		Advocate (as applicable)	<input type="checkbox"/>
		Case Manager	<input type="checkbox"/>
			<input type="checkbox"/>

As a consumer, family member, guardian or advocate, please contact your case manager within two weeks of receipt if you do not agree with this plan as written.

As a consumer, family member, guardian or advocate, you have the right to request a Programmatic Administrative Review pursuant to Policy DDS-7, if you disagree with any portion of the plan.

Comments:



State of Connecticut
Department of Developmental Services

DDS

Dannel P. Malloy
Governor

Morna A. Murray, J.D.
Commissioner

{DATE}

Fritz Gorst
West Region Director

{NAME AND ADDRESS}

RE: {INDIVIDUALS NAME}

Dear Ms. {LAST NAME}

The region's Planning and Resource Allocation Team has reviewed your family members need for residential support. Using the Priority Checklist, your priority level has been determined and you have been assigned a **Priority 1** for residential service. Your priority assignment will be re-evaluated by your Case Manager at least annually, when your Individual Plan is reviewed, or sooner if your situation should change. Please contact your case manager if you have any questions regarding this determination.

If you do not agree with your Priority Assignment you have the right to request a Programmatic Administrative Review (PAR) with the Regional Director, which is an informal dispute resolution, and/or an Administrative Hearing with DDS, which is a formal hearing process established by law. Enclosed is a set of Frequently Asked Questions (FAQs) about each of these dispute resolution processes. The forms for filing these dispute resolutions can be obtained from your case manager or from the following web links:

PAR Form: http://www.dmr.state.ct.us/forms/Request_for_PAR.pdf

Hearing Form: http://www.dmr.state.ct.us/forms/UAPA_Priority_Hearing_Request.pdf. Please contact your case manager if you would like further explanation of these options for dispute resolution or assistance with filing the request(s).

Sincerely,

Tammy R. Garris

Tammy Garris
PRAT/Waiver Manager

cc. {CM FIRST INTIAL/LAST NAME}, CM
File



Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

First Notice

Date:

Re: DDS#:

A review of records indicates that _____ is receiving residential, day and/or individual support services that are funded by the Department of Developmental Services.

Subsection g of section 17a-218 of the Connecticut general Statutes requires all individuals who receive substantive services from DDS to enroll in the DDS Medicaid Home and Community Based Services Waiver.

If you do not qualify for Medicaid at this time due to earned and/or unearned income, asset resources, trusts, etc., you must provide documentation of income, assets, and trusts to your case manager.

Please contact your case manager within **10 days** to complete the waiver enrollment process, or, to submit the requested supporting documentation of Medicaid ineligibility within 30 days from the date of this letter. Please be advised that failure to contact your case manager will result in a case review which may lead to the termination of DDS funding for supports and services.

Please see the attached factsheet for additional information.

Supervisor of Case Management



Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

Second Notice

Date:

Re: DDS#:

This is a follow-up to the letter you received dated _____.

Please be advised that failure to contact your case manager to complete the waiver enrollment process or, to submit the requested supporting documentation of Medicaid ineligibility within 30 days from the date of the first letter dated _____ will result in a case review which may lead to the termination of DDS funding for supports and services.

Please contact your case manager to avoid termination.

Regional Director or designee

Attach factsheet
Copy DDS.Waiver@ct.gov



Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

Final Notice

Date:

Re: DDS#:

DDS has made several attempts to address the waiver enrollment and/or Medicaid application process for _____.

You were notified that termination of DDS funding for supports and services would occur at the end of 30 days from your original letter dated _____. Our records indicate that you have not made contact with your case manager, which has resulted in termination of DDS funding for support and services effective the end of this month.

If you believe you have received this letter in error. Please contact the DDS Waiver Unit at:

Department of Developmental Services
HCBS Waiver Unit
460 Capitol Avenue
Hartford, CT 06106
Phone: 860-418-6028
Fax: 860-622-2769
Email: DDS.Waiver@ct.gov

Please contact your case manager to avoid termination.

Note you have the right to appeal this decision through the Fair Hearing Process at DSS. See the attached form and factsheet for additional information.

DDS Waiver unit sends this letter
Copy provider
Copy regional Director

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001
460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov
An Affirmative Action/Equal Opportunity Employer

