MONEY FOLLOWS THE PERSON

ASSESSMENT & PERSONAL HISTORY

Assessment Date: _____

PERSONAL DATA (of individual seeking services)

1. Last Name _____ First _____ Middle _____
2. Maiden name or Other (_____)
3. Address: _____
4. Phone: (_____) _____-_____ ☐ Consumer ☐ Other (_____)
5. SSN: _____-_____-_____ Culture/Race: _____ DOB:_____ Age:___
6. Gender: Male ☐ Female ☐
7. U.S. Citizen Yes ☐ No ☐
8. Marital Status: ☐ Single (never married) ☐ Married ☐ Divorced
9. Spoken Language: ☐ English ☐ Spanish ☐ Other _____
   Written Language: ☐ English ☐ Spanish ☐ Other _____
   Preferred communication (How does applicant communicate? Examples: speaks in sentences, single words, sign language, picture cards, point, etc.)
   _____
10. Date of Admission to current Nursing Home (N/A if not applicable): _____
11. Previous Nursing Home admission and discharge date (N/A if not applicable): _____
12. Do you have Advanced Health Care Directive? ☐ Y ☐ N
13. **Medicaid Recipient** ☐ **Y** ☐ **N** **Medicare Recipient** ☐ **Y** ☐ **N**
    Does applicant have any income? Yes ☐ No ☐ If Yes, specify (below) monthly amount & type
    Please list AFDC, VA, SSI, Child Support, Trusts and Payee:

Type	Amount	Individual	Payee
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. FACILITY INFORMATION (Current or most recent placement. Write N/A if not applicable)

Name of Facility: _____

Address: _____ City: _____ State: ____ Zip: _____ County: _____

Contact/Title: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____

Physician: _____ Phone: (_____) _____-_____

WHAT WAS YOUR REASON FOR ENTERING THE FACILITY?

Check all that apply.

A ☐ Treatment for medical condition

B ☐ Health or personal care problems while in community

C ☐ Unable to return home from hospital/rehab facility

D ☐ Difficulty in maintaining community residence

Comments:

Facility Representative: _____ Phone # _____

Family Information:

Guardian/custodian name: _____

Address: _____

Phone number(s): _____

Power of Attorney to: _____ Type of Power of Attorney: _____

Birth/Adoptive **Father** (circle one)

Name: _____ Date of Birth: _____

Address: _____ Phone: (____)_____-_____ Ext:_____

_____

Employer's Name: _____ Phone: (____)_____-_____Ext: _____

Deceased ☐ Retired ☐ Disabled ☐ Military (Active) ☐ (Retired) ☐

Military Branch: _____ Salary Estimate(any source):_____

Birth/Adoptive **Mother** (circle one)

Name: _____ Date of Birth: _____

Address: _____ Phone: (____) _____ - _____ Ext:_____

_____

Employer's Name: _____ Phone: (____) _____ - _____Ext: _____

(Mother, continued) Deceased ☐ Retired ☐ Disabled ☐ Military (Active) ☐ (Retired) ☐

Military Branch: _____ Salary Estimate (any source): _____

Step Parents: List name, address, and telephone number:

_____

For applicants 18 years and older Only (use back of form if needed)**:**

A. List all past living arrangements: (i.e. with parents, group home, apartment, HDC, own home, etc.)

_____

B. List all past jobs: _____

MEDICAL CONDITION AND PROFESSIONAL CARE NEEDS

1. Physical Description:

Hair Color: _____ Eye Color: _____

Height: _____ Weight: _____

2. Primary Medical Diagnoses: _____

3. Diagnosis: (Check and complete appropriate blanks)

- ☐ Developmental Delay
- ☐ At risk for delay due to medical condition (Identify condition) _____
- ☐ Intellectual Disability (e.g. Mental Retardation, level, if known) _____
- ☐ Down Syndrome _____
- ☐ Epilepsy _____
- ☐ Seizures (type/frequency) _____
- ☐ Cerebral Palsy (functioning level, if known) _____
- ☐ Autism (functioning level, if known) _____

☐ Other (please explain) _____

Other Medical Diagnoses and Treatment: _____

Other Psychiatric Diagnoses and Treatment: _____

Age at which primary diagnosis was made or condition was noticed? _____

4. Medical History:

A. Birth Information:

Problems during pregnancy: (explain) _____

Complications with birth: (explain) _____

B. Individual's Information (use back of page for more space):

Current Medications/Dosages (attach page if needed):_____

History of any significant injuries and dates: _____

Allergies: _____

Special Precautions/Instructions/Diet: _____

Has the applicant been tested for vision? Yes ☐ No ☐ If yes, when? _____

Where? _____ What were you told? _____

Hearing? Yes ☐ No ☐ If yes, when? _____

Where? _____ What were you told? _____

Dental? Yes ☐ No ☐ If yes, When? _____

Where? _____ What were you told? _____

Speech Impaired? ☐ None ☐ Mild ☐ Moderate ☐ Severe

☐ Hearing Aid ☐ Sign Language ☐ Difficulty Understanding Conversation

5. Developmental/Behavioral Profile: (For DDS applicants only.)

Early Childhood – (In months, if known) When did applicant first:

Sit alone	☐ Yes	Age _____	Not yet able ☐
Crawl	☐ Yes	Age _____	Not yet able ☐
Walk alone	☐ Yes	Age _____	Not yet able ☐
Make sound/babble	☐ Yes	Age _____	Not yet able ☐
Single word	☐ Yes	Age _____	Not yet able ☐
Phrases/Sentences	☐ Yes	Age _____	Not yet able ☐
Toilet Trained	☐ Yes	Age _____	Not yet able ☐
Bowel	☐ Yes	Age _____	Not yet able ☐
Bladder	☐ Yes	Age _____	Not yet able ☐
Dry at night	☐ Yes	Age _____	Not yet able ☐

Understood by caregiver ☐ Yes Age _____ Number of words _____ Not yet able ☐

Understood by others ☐ Yes Age _____ Number of words _____ Not yet able ☐

FUNCTIONAL ASSESSMENT

Activities of Daily Living	Completely Able	Prompting Only	Able with Help/Device	Completely Unable	Who Assists?
Bathing					
Dressing/Undressing					
Eating					
Toileting					
Bladder Continence					
Bowel Continence					
Getting In/Out of Bed					
Walk Around Inside		**n/a**			
Walk Around Outside		**n/a**			
Stair Climbing					
Wheeling (if applicable)					
Grooming/Hygiene					
Communicate		**n/a**			
See		**n/a**			
Hear		**n/a**			

Instrumental Activities Of Daily Living	Completely Able	Prompting Only	Able with a Little Help	Able with a Lot of Help	Completely Unable	Who Assists?
Meal Preparation						
Light Housework						
Laundry						
Shopping						
Taking Medicine						
Transportation (travel alone)						
Money (purchasing)						
Money Management (bills, etc.)						
Telephone Use						
Care/Supervision of Children (if applicable)						
Work Independently						
Read						

Write/Print						

Other: *(Please Specify)*

INVENTORY OF COMMUNITY SERVICE AND SUPPORT NEEDS

Housing

1. **Rate Preference for Living Arrangement** (1 = First Choice; 2 = Second Choice, etc.)

☐ A. Alone in your home or apartment ☐ B. Live with Family

☐ C. Live with friend(s) ☐ D. Assisted Living Facility

☐ E. Foster Care or Alternate Family Placement ☐ F. Other_____

2. **Desired Location:** (City/County) _____

3. **Accessibility Requirements:** (Check All That Apply)

☐ Widened Doorways ☐ No Step Entrance ☐ No Stairs

☐ Bathroom Handrails ☐ Roll-In Shower ☐ Automatic Door Opener

☐ Environmental Control System ☐ Entrance Ramp ☐ W/C Access Kitchen

☐ 1st Floor Apartment ☐ Curb Cut ☐ Other _____

4. **Require Location Within Public Transit Area** ☐ Yes ☐ No

5. **If Living Arrangements Have Been Identified**

☐ A. With others Planning to live with whom? _____

☐ B. Independent Residence Where? _____

☐ C. Foster Care Foster Care contact: _____

☐ D. Assisted Living Facility Facility Name: _____

☐ E. Other _____ Desired Location: _____ Desired Agency: _____

Address: _____City: _____ State: _____ Zip: _____

Contact: _____ Phone: (_____)_____-_____

Type of Residence: → ☐ House ☐ Apartment ☐ Guest House

Status: → ☐ Room Available ☐ Agreement ☐ Would Pay Rent

Roommate: → ☐ Needed ☐ Available ☐ Will Share Rent

Condition: → ☐ Already Modified ☐ Repair/Renovation Needed

In summary, what is the guardian's/family's preference for a living arrangement for the service recipient?

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6. Services Requested and Current Situation:

A. What assistance is needed, and why? _____

B. Does individual presently reside with his/her own family? Yes ☐ No ☐

If no, please explain. _____

C. Is present living situation satisfactory? Yes ☐ No ☐

If not, what is needed? _____

Please list current service providers (use back of page for additional space, if needed):

A. List agencies, schools, programs, etc., presently assisting applicant, and services provided. _____

_____

School(s) applicant is presently attending: _____

School previously attended if no longer in school: _____

Graduated with diploma: Yes ☐ No ☐ If yes, when? _____ Received GED: Yes ☐ No ☐

Graduated with a Certificate of Completion: Yes ☐ No ☐ If yes, when? _____

Was applicant in Special Education Classes? Yes ☐ No ☐

If yes, what years? _____

Professional Service Providers:

Pediatrician _____Phone #:_____

Family Doctor _____ Phone #:_____

Dentist _____ Phone #:_____

Nurse _____ Phone #:_____

Orthopedist _____ Phone #:_____

Ear, Nose and Throat Specialist _____ Phone #:_____

Ophthalmologist _____ Phone #:_____

Psychiatrist/Psychologist _____ Phone #:_____

Audiologist _____ Phone #:_____

Speech Therapist _____ Phone #:_____

Occupational Therapist _____ Phone #:_____

Physical Therapist _____ Phone #:_____

Social Worker _____ Phone #:_____

Dietician _____ Phone #:_____

Others (Please specify) _____ Phone #:_____

B. List other agencies, schools, training facilities and programs that have assisted applicant. (Include services they provided and the outcomes): _____

_____

C. Any past services requested from DDS or other agencies including whether or not services were received and if not received, why? -

_____

EMOTIONAL AND BEHAVIORAL ISSUES

DO YOU:

- ☐ Feel Lonely
- ☐ Have Sleep Problems
- ☐ Lose Interest

ARE YOU:

- ☐ Not Eating
- ☐ Worried, Anxious
- ☐ Feeling Depressed

WORKER OBSERVATIONS:

- ☐ Abusive or Assaultive
- ☑ Wandering
- ☑ Unsafe or Unhealthy Hygiene or Habits
- ☐ Threats to Health or Safety
- ☐ Inappropriate Social/Sexual Behaviors
- ☐ Appears Angry
- ☐ Fearful
- ☐ Client Requires Supervision Due to These Behaviors
- ☐ Shaky, Trembling, Crying
- ☐ Depressed Affect
- ☐ Appears Suspicious
- ☐ Poor Judgment
- ☐ Impaired Judgment
- ☐ Suicidal (Talk/Attempts)

Cognitive/Behavior: If the individual is unable to answer, solicit information from another source and Identify source:

_____

☐ Memory Loss ☐ Behavioral Concerns _____

☐ Wandering ☐ Anxiety

☐ History of Alcohol/Drug abuse (please explain): _____

☐ Episodes of abuse: _____

☐ Other (please explain) _____

Have you experienced any Major Life Changes (Crises) in the past year? Yes ☐ No ☐

(E.g., Loss of family member, pet, previous abilities, home, etc.) If yes, explain:_____

Behavioral:

Does applicant have challenging behavior/temper tantrums? Yes ☐ No ☐

Please describe: _____

Describe applicant's typical behavior with regard to:

Activity level: _____

Aggressive or passive: _____

Reactions to others (e.g. family, friends): _____

Describe any unusual/extreme behavior of applicant (and frequency) with regard to:

Reaction to authority (e.g. police, supervisors, teachers): _____

Non-Compliant/oppositional behaviors: (If yes, explain/describe) _____

Any self-stimulatory behaviors: (describe) _____

Any sexual behaviors: _____

Any self-harm behaviors: _____

Legal issues/pending charges/arrests: _____

List alternate placement options and efforts: (Give dates) _____

Identify:

COMMUNITY-BASED SUPPORTS

Please Think of Your Relatives (besides those who live in your house/apartment) **to whom you feel close. For example, your children, brothers, sisters, spouse, other relatives or friends. What are their names and their relationship to you?**

Name	Relationship	Telephone

Do you have any friends or neighbors who would be available if you need help? **Yes** ☐ **No** ☐

Identify:

Who is your main caregiver? _____

How is this person's health? ☐ **Good** ☐ **Fair** ☐ **Po**

Personal History

Additional information necessary in making a determination: **(It is vitally important that all aspects and issues are considered in order to be successful in assisting participants to move to the community. If we have time to plan, we can manage the issues and complete a successful move. These issues are not used to screen individuals out of the transition process.)**

1. What is your reputation within community agencies? (For example, care agencies that refuse to serve you because of past conflicts.)

☐ Poor ☐ Fair ☐ Good ☐ Excellent

What agencies have provided services for you in the past?

2. Do you have unpaid utility bills? (For example, electric, water, gas or phone bills from your last home or apartment)

☐ Yes ☐ No

Please list the names of utility companies where you have unpaid bills:

3. Do you have credit history problems? (For example, rental history problems, credit card debts, etc.)

☐ Yes ☐ No

Please indicate the circumstances:

4. Have you had any problems with the police? (For example DWI, outstanding , warrants for your arrest, etc.)

☐ Yes ☐ No

Please indicate the circumstances:

5. Do you have a history of family problems? (For example, domestic battery, etc.)

☐ Yes ☐ No

Please indicate the circumstances:

6. Do you have a history of substance abuse? (For example, personal history with alcohol or illegal drugs that included job losses, legal problems, evictions, etc. or a history of associating with people that engage in substance abuse.)

☐ Yes ☐ No

Please describe the circumstances:

Impressions of coordinator and areas of concern:

EMPLOYMENT

When you leave the facility, are you interested in working ? **Yes** ☐ **No** ☐

Will you need assistance accessing opportunities for employment? **Yes** ☐ **No** ☐

Client's Name: _____ Date_____

Client's Signature: _____ Date _____

Assessment completed by (Name & Title): _____

Relationship to applicant: _____

Date completed: _____

Email Address _____ Contact Number: (_____) _____-_____

Comments/Clarifications/Other Information: