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| **NH Bureau of Developmental Services Functional Screen for Waiver Services** | | | | | |
| **APPLICANT'S DEMOGRAPHIC INFORMATION** | | | | | |
| Applicant Name (first) | Middle Initial | | Last | | Suffix |
| Gender  Female  Male | Applicant's Medicaid I.D. | | Date of Birth (mm/dd/yyyy) | | Area Agency (number and name) |
| Applicant's Street Address: | | | | | |
| City | State | | Zip Code | | |
| Telephone - Home | Telephone - Work | | Telephone – Cell | | |
| **GUARDIANSHIP** | | | | | |
| Individual has court appointed guardian  Yes  No If "Yes" provide guardian information | | | | | |
| Name (First) | Middle | | Last | | |
| Address: | | | | | |
| City | State | | Zip Code | | |
| Telephone - Home | Telephone - Work | | Telephone – Cell | | |
| **TARGET GROUP: Indicate one Waiver selection** | | | | | |
| DD Waiver | | ABD Waiver | | IHS Waiver | |
| Does the applicant have a disability determination from a qualified medical professional?  Yes  No | | | | | |
| **RESIDENTIAL SERVICES (must select one)** | | | | | |
| He-M 521  Independent Living  He-M 525  License Facility #  He-M 1001  N/A  EFC Certified #:  Staffed Residence Certified #: | | | He-M 507 Certification #  He-M 521  He-M 525  N/A | | |
| **CLINICAL INFORMATION - to be completed by a person with knowledge of the individual's current clinical status.** | | | | | |
| **DIAGNOSES: Check all those documented in individual's medical record; at least one must be selected.** | | | | | |
| Intellectual Disability:  Mild  Moderate  Severe  Epilepsy / Seizure Disorder  Autism Spectrum Disorder  TBI onset prior to age 21  Downs Syndrome  Cerebral Palsy  Learning Disability (please specify):  Other Qualifying Condition / Syndrome (please specify): | | | | | |
| **ACQUIRED BRAIN DISORDER** | | | | | |
| Traumatic Brain Injury onset after age 22, prior to age 60  Anoxia  Cerebral Vascular Accident (CVA, Stroke)  Brain Tumor  Infectious brain disease (specify):        Intracranial Surgery  Other Neurological Disorders (Huntington’s, MS, etc.): | | | | | |

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| **OTHER MEDICAL CONDITION(S):** | | | | |
| Underlying medical condition which effects level of care, if any (please specify): | | | | |
| **MENTAL ILLNESS:** | | | | |
| Anxiety Disorder (PTSD, OCD)  Bipolar Disorder | | Major Depression  Schizophrenia | | Personality Disorder (specify):  Other (specify): |
| **IMPAIRMENTS:** | | | | |
| Visual  Yes  No  Speech  Yes  No  Hearing  Yes  No | Paralysis  Yes  No  Joint Motion  Yes  No | | Specialty Care: Other:  G-Tube  Yes  No  Vent / Trach  Yes  No  Oxygen  Yes  No | |
| **ONGOING THERAPIES** | | | | |
| OT  PT  Speech | | | | |

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| **LEVEL OF ASSISTANCE SCALE** | | | |
| **0** - Person is **completely** independent in his/her ability to safely accomplish task. | | | |
| **1** - Assistance, including supervision, cueing, or hands-on, is necessary for the individual to complete the task safely, but **helper DOES NOT have to be physically present throughout.** | | | |
| **2** - Assistance, including supervision, cueing, and/or hands-on assist, is necessary to safely complete the task with **helper present throughout** or task is not age appropriate. | | | |
| **ADLs (Activities of Daily Living)** | | | Select only one box |
| **BATHING** | The ability to shower and/or bathe to maintain adequate hygiene, including the ability to: get in and out of the shower and/or tub; turn faucets on and off; regulate water temperature; wash; and dry fully. | | 0  1  2 |
| **Select all adaptive equipment used, if any:**  Grab Bar(s) Shower Chair Tub Bench Mechanical Lift | | |
| **DRESSING** | The ability to dress/undress including selection of weather appropriate clothing, completed with or without assistive devices; this includes fine motor coordination for buttons and zippers on the front of clothing (do not include difficulties with zippers and/or buttons at the back of an article of clothing). | | 0  1  2 |
| **EATING** | The ability to eat and drink using routine or adaptive utensils, this includes the ability to cut, chew, and swallow food. Note: If individual is fed via tube or intravenous, check "0" if they can accomplish task themselves, or "1" or "2" if assistance is required. | | 0  1  2 |
| **MOBILITY IN HOME** | The ability to move between locations in the individual's living environment-defined as kitchen, living room, bathroom, and sleeping area (excluding basements, attics, yards, and any equipment used outside the home). | | 0  1  2 |
| **Indicate all adaptive equipment used, if any:**  Cane in Home  Quad-Cane in Home  Wheelchair/Scooter in Home  Crutches in Home  Prosthesis  Walker in Home  Person assist/other physical support:  One person  Two Person | |  |
| **PERSONAL HYGIENE** | How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (exclude baths and showers) | | 0  1  2 |
| **TOILET USE** | The ability to use the toilet, commode, bedpan, or urinal, including ability to transfer on/off the toilet, cleansing of self, managing an ostomy or catheter, and adjusting clothes. | | 0  1  2 |
| **Indicate all adaptive equipment/strategies used, if any:**  Grab Bar(s)  Ostomy  Commode or adaptive equipment  Training Protocol  Urinary Catheter | | |
| **BLADDER** | **INCONTINENCE:**  *not including stress incontinence*  Does not have incontinence  Has incontinence daily  Has occasional incontinence | | |
| **BOWEL** | **INCONTINENCE:**  *not including stress incontinence*  Does not have incontinence  Has incontinence daily  Has occasional incontinence | | |
| **TRANSFERRING** | The ability to get in and out of bed and to move between surfaces: bed/chair to wheelchair, walker or standing position (include the ability to use assistive devices  for transfer).  One person  Two Person | | 0  1  2 |
| **Select all adaptive equipment used, if any:**  Grab Bar(s)  Slide Board  Gait Belt Mechanical Lift | | |
| **IADLs (Instrumental Activities of Daily Living)** Select only one box | | | | |
| **MEAL PREPARATION** | | Independent  Needs assistance weekly (e.g., meal planning, grocery shopping)  Needs help with every meal | | |
| **MEDICATION**  **ADMINISTRATION AND**  **MANAGEMENT** | | Has no medication  Self-Administering / Fully Independent  Self-Administering with Supports  Is required to have medications administered | | |
| **MONEY MANAGEMENT** | | Independent  Needs assistance managing finances  Needs assistance from another person with all transactions | | |
| **LAUNDRY and/or**  **CHORES** | | Independent  Needs assistance from another person weekly or less often  Needs assistance more than once a week | | |
| **TRANSPORTATION** | | Individual holds a valid driver's license  Individual is able to take public transportation  Individual cannot drive due to impairment(s) | | |
| **EMPLOYMENT/VOLUNTEER** | | | | |
| *Section concerns the need for assistance to perform employment specific activities. The need for help with ADLS and IADLs (e.g., transportation, personal care) is captured in other sections, this section concerns only those supports necessary for successful performance of job duties.* | | | | |
| **A. Current Employment Status (select all that apply):**  Working full-time (paid work avg 30 or more hours per week)  Retired (age 65+ only)  Working part-time (paid work avg less than 30 hours per week)  Volunteer  Not Working (engages in no paid work) | | | | |
| **B. Need for Assistance to Work/Volunteer (select one):**  Independent (includes use of assistive devices or natural supports)  Needs assistance weekly or less (e.g., if a problem arises)  Needs assistance daily, but does not need the continuous presence of another person.  Needs the continuous presence of another person | | | | |

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| **COMMUNICATION AND COGNITION** |
| **Communication** (select one) Ability to express oneself, including non-English languages, American Sign Language, or other generally recognized communication strategy with or without assistive technology.  Able to fully communicate without impairment or with minor impairment (e.g., slow speech)  Able to fully communicate with the use of assistive device  Able to communicate basic needs to others and/or comprehend basic language  No effective communication |
| **Memory Loss** (select all that apply):  No memory impairments evident  Short-term memory loss (seems unable to recall things a few minutes up to 24 hours later)  Unable to remember things over several days or weeks  Long-term memory loss (seems unable to recall distant past)  Memory impairments are unknown or unable to determine |
| **Cognition for Daily Decision Making** (select one)  Independent – decisions consistent / reasonable  Modified independence – some difficulty in new situations only  Moderately impaired – decision poor; cues / supervision required  Severely impaired – never / rarely made decisions |
| **Executive Dysfunction** (check all that apply)  Lack of awareness  Impulsivity and disinhibition  Lack of initiation  Diminished problem solving  Diminished organization and planning |
| **Resistant to Care** (select one)  Yes, individual is resistive to care due to a cognitive impairment  No |
| **Supervision**  No supervision required in any setting  Access to 24 Hour supervision  Less than 24; indicate # of hours per day:        Continuous 24 hour supervision |
| **BEHAVIOR(S)/MENTAL HEALTH** |
| **Wandering (select one)** Individual has cognitive impairments and leaves residence/immediate area without informing  Does not wander  Wanders during the day, but sleeps nights  Wanders at night, or wanders day and night |
| **Self-Injurious Behaviors (select one)** Behaviors that cause or could cause injury to one's own body, including: physical self-abuse (hitting, biting, head banging, etc.), pica (eating inedible objects), and etc.  Demonstrates no self-injurious behavior  Some self-injurious behaviors requiring intervention weekly or less frequently  Self-injurious behaviors requiring interventions more than twice each week  Self-injurious behaviors require intensive one-on-one interventions more than twice each day  Indicate behavior(s) exhibited: |
| **Offensive or Violent Behavior toward others (select one):** Behaviors that causes others significant pain, substantial distress, or law enforcement typically called to intervene.  Demonstrates no offensive or violent behaviors  Some offensive or violent behaviors require occasional interventions weekly or less  Offensive or violent behaviors require interventions more than twice each week  Offensive or violent behaviors require intensive one-on-one interventions more than twice each day  Indicate behavior(s): |
| **Substance Use (check all that apply)**  No active / history of substance use issues evident at this time  History of substance abuse issues, but no current or active use issues evident at this time.  Active or recent (within one year, concerns of substance abuse, reported by individual or others. |

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| **RISK TO COMMUNITY SAFETY (check all that apply):** |
| No known history of problematic sexual behavior, arson and/or violence  History of problematic sexual behaviors, arson and/or violence WITHOUT legal involvement  History of legal involvement related to problematic sexual behaviors, arson and/or violence  Individual reports deviant thinking related to thoughts of sexual offending, fire setting, or violence |

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| **If initial request for services or no waiver services provided in the past year:** | | | | | |
| Signature of Dr/RN completing form: |  | | Date Signed | |  |
| Print Name and phone # of Dr/RN completing form: | |  |  |  | |
|  | | Name |  | Phone | |

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| **If change / services renewal:** | | | | | |
| Service Coordinator |  | | Date Signed | |  |
| Name and phone # of person completing form: | |  |  |  | |
|  | | Name |  | Phone | |