

## NH Bureau of Developmental Services Functional Screen for Waiver Services

### APPLICANT'S DEMOGRAPHIC INFORMATION

Applicant Name (first)		Middle Initial	Last	Suffix
Gender <input type="checkbox"/> Female <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> DD Waiver	<input type="checkbox"/> ABD Waiver	<input type="checkbox"/> IHS Waiver
Does the applicant have a disability determination from a qualified medical professional?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

RESIDENTIAL SERVICES (must select one)	DAY SERVICES (must select one)
<input type="checkbox"/> He-M 521	<input type="checkbox"/> Independent Living
<input type="checkbox"/> He-M 525	<input type="checkbox"/> License Facility # _____
<input type="checkbox"/> He-M 1001	<input type="checkbox"/> NA
<input type="checkbox"/> EFC Certified # _____	<input type="checkbox"/> He-M 507 Certification Number: _____
<input type="checkbox"/> Staffed Residence Certified # _____	<input type="checkbox"/> He-M 521
	<input type="checkbox"/> He-M 525
	<input type="checkbox"/> NA

### 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.

<b>Developmental Disability:</b>	
<input type="checkbox"/> Intellectual Disability: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Epilepsy/Seizure Disorder
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> TBI onset prior to age 21
<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Learning Disability (please specify) _____	
<input type="checkbox"/> Other Qualifying Condition/Syndrome (please specify) _____	

<b>Acquired Brain Disorder:</b>	
<input type="checkbox"/> Traumatic Brain Injury onset after age 22, prior to age 60	<input type="checkbox"/> Anoxia
<input type="checkbox"/> Cerebral Vascular Accident (CVA, Stroke)	<input type="checkbox"/> Brain Tumor
<input type="checkbox"/> Infectious brain disease (specify) _____	<input type="checkbox"/> Intracranial Surgery
<input type="checkbox"/> Other Neurological Disorders (Huntingtons, MS, etc.): _____	

<b>Other Medical Condition(s):</b>
<input type="checkbox"/> Underlying medical condition which effects level of care, if any (please specify) _____

<b>Mental Illness:</b>		
<input type="checkbox"/> Anxiety Disorder (PTSD, OCD)	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Personality Disorder (specify): _____
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Other (specify): _____

<b>Impairments:</b>		<b>Specialty Care:</b>		Other: _____
Visual <input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No	G-Tube <input type="checkbox"/> Yes <input type="checkbox"/> No		
Speech <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Motion <input type="checkbox"/> Yes <input type="checkbox"/> No	Vent/Trach <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No		Oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Therapies:</b>	OT: <input type="checkbox"/> Yes <input type="checkbox"/> No	PT: <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**ADLs (ACTIVITIES OF DAILY LIVING)**

**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.

**IADLs (Instrumental Activities of Daily Living)**

Select only one  
box

<b>BATHING</b>	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.	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2
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**Select all adaptive equipment used, if any:**

Grab Bar(s)     
  Shower Chair     
  Tub Bench     
  Mechanical Lift

<b>DRESSING</b>	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).	<input type="checkbox"/> 0
		<input type="checkbox"/> 1
		<input type="checkbox"/> 2

<b>EATING</b>	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.	<input type="checkbox"/> 0
		<input type="checkbox"/> 1
		<input type="checkbox"/> 2

<b>MOBILITY IN HOME</b>	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).	<input type="checkbox"/> 0
		<input type="checkbox"/> 1
		<input type="checkbox"/> 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

<b>TOILETING</b>	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.	<input type="checkbox"/> 0
		<input type="checkbox"/> 1
		<input type="checkbox"/> 2

**Indicate all adaptive equipment/strategies used, if any:**

Grab Bar(s)                                     
  Ostomy  
 Commode or adaptive equipment             
  Training Protocol  
 Urinary Catheter

**INCONTINENCE:** *not including stress incontinence*

Does not have incontinence                     
  Has incontinence daily  
 Has occasional incontinence                     
  Regular training protocol

<b>TRANSFERRING</b>	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).	<input type="checkbox"/> 0
		<input type="checkbox"/> 1
		<input type="checkbox"/> 2

**Select all adaptive equipment used, if any:**

Grab Bar(s)     
  Shower Chair     
  Tub Bench     
  Mechanical Lift

**IADLs (Instrumental Activities of Daily Living)**

Select only one  
box

<b>MEAL PREPARATION</b>	Independent	<input type="checkbox"/> 0
	Needs assistance weekly (e.g., meal planning, grocery shopping)	<input type="checkbox"/> 1
	Needs help with every meal	<input type="checkbox"/> 2

<b>MEDICATION ADMINISTRATION AND MANAGEMENT</b>	Has no medication	<input type="checkbox"/> 0
	Self-Administering/Independent (with or without assistive devices)	<input type="checkbox"/> 1
	CANNOT direct the task; is required to have medications administered	<input type="checkbox"/> 2
<b>MONEY MANAGEMENT</b>	Independent	<input type="checkbox"/> 0
	Needs monitoring	<input type="checkbox"/> 1
	Needs help from another person with all transactions	<input type="checkbox"/> 2
<b>LAUNDRY and/or CHORES</b>	Independent	<input type="checkbox"/> 0
	Needs help from another person weekly or less often	<input type="checkbox"/> 1
	Needs help more than once a week	<input type="checkbox"/> 2
<b>TRANSPORTATION</b>	Individual drives regular vehicle	<input type="checkbox"/> 0
	Individual is able to take public transportation	<input type="checkbox"/> 1
	Individual cannot drive due to impairment(s), including no driver's license.	<input type="checkbox"/> 2

**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 one):**  
 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 if needed)  
 Needs help weekly or less (e.g., if a problem arises)  
 Needs help daily, but does not need the continuous presence of another  
 Needs the continuous presence of another person

**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 one):  
 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 - Individual makes decisions that are generally consistent with his/her own lifestyle, values and goals (not necessarily in alignment with professionals' values and goals).  
 Individual makes safe decisions in familiar situations, but needs help with new tasks or challenging situations.  
 Person needs help from another person most or all of the time to ensure safe decision-making

**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 (select one, two if court ordered)**  
 No supervision required       24 Hour supervision  
 Less than 24; indicate # of hours per day: \_\_\_\_\_       Court Ordered

**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 2-6 times per week OR 1-2 times per day  
 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 2-6 times per week OR 1-2 times per day  
 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 substance use issues evident at this time  
 Individual or others report substance use issue, evidence suggests possibility of a current issue, or a high likelihood of  
 In the past year, the person has had significant problems due to substance use issues, examples include: *police intervention, detox, inpatient treatment, job loss, and/or major life changes.*

**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

**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

**If change/services renewal:**

Service Coordinator: \_\_\_\_\_ Date Signed \_\_\_\_\_  
 Name and phone # of person completing form: \_\_\_\_\_  
 Name Phone