

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)

<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"/> Staffed Residence Certified # _____	

DAY SERVICES (must select one)

<input type="checkbox"/> He-M 507	Certification Number: _____
<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.

Developmental Disability:	
<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) _____	

Acquired Brain Disorder:

<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.): _____	

Other Medical Condition(s):

<input type="checkbox"/> Underlying medical condition which effects level of care, if any (please specify) _____
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Mental Illness:

<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): _____

Impairments:

Visual <input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis <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
Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	

Specialty Care:

Other: _____
G-Tube <input type="checkbox"/> Yes <input type="checkbox"/> No
Vent/Trach <input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No

Therapies:	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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MEDICATION ADMINISTRATION AND MANAGEMENT	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
MONEY MANAGEMENT	Independent	<input type="checkbox"/> 0
	Needs monitoring	<input type="checkbox"/> 1
	Needs help from another person with all transactions	<input type="checkbox"/> 2
LAUNDRY and/or CHORES	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
TRANSPORTATION	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