



**PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.**

5. Mobility

- Walks independently
- Walks with supportive devices
- Walks unaided with difficulty
- Uses wheelchair operated by self
- Uses wheelchair & needs help
- No mobility

Communication

- Speaks and can be understood
- Speaks and is difficult to understand
- Uses gestures
- Uses sign language
- Uses communication board or device
- Does not communicate

Comments: \_\_\_\_\_ Comments: \_\_\_\_\_

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6. How much time is required for assuring safety?

- Requires less than 8 hours per day on average
- Requires 9-16 hours daily on average
- Requires 24 hours (does not require awake person overnights)
- Requires 24 hours with awake person overnight
- Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

Comments: \_\_\_\_\_

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7. How much assistance is needed for daily living tasks?

- No assistance** needed in **most** self-help and daily living areas and **Minimal assistance (use of verbal prompts or gestures as reminders)** needed in **some** self-help and daily living areas, and **Minimal to complex assistance** needed to complete skills such as financial planning and health planning.
- No assistance** in **some** self-help, daily living areas, and **Minimal assistance** for many skills, and **Complete assistance (caregiver completes all parts of task)** needed in **some** basic skills and all **complex** skills.
- Partial (use of hands on guidance for part of task) to complete assistance** needed in most areas of self-help, daily living, and decision making, and Cannot complete **complex** skills
- Partial to complete assistance** is needed in **all areas** of self-help, daily living, decision making, and complex skills

- Extreme Need:** All tasks must be done for the individual, with no participation from the individual

Comments: \_\_\_\_\_

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8. How often are doctor visits needed?

- For routine health care only / once per year  
 2-4 times per year for consultation or treatment for chronic health care need  
 More than 4 times per year for consultation or treatment  
 **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

Comments: \_\_\_\_\_

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9. How often are nursing services needed?

- Not at all  
 For routine health care only  
 1-3 times per month  
 Weekly  
 Daily  
 **Extreme Need:** Several times daily or continuous availability

Comments: \_\_\_\_\_

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10. Are there behavior problems?      Yes       No

*IF YES - PLEASE CHECK ALL THAT APPLY.*

- Self Injury  
 Aggressive towards others  
 Inappropriate sexual behavior  
 Property destruction  
 Life threatening (threat of death or severe injury to self or others)  
 Takes prescribed medications for behavior control

***PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.***

11. Where is the individual currently living?

- |  |  |
|--|--|
| <input type="checkbox"/> Living with family/relative         | <input type="checkbox"/> Living in own home or apartment |
| <input type="checkbox"/> Group home or personal care home    | <input type="checkbox"/> Nursing home                    |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend            |

12. Does the individual currently receive any of the following services? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Supported Living               | <input type="checkbox"/> Medicaid EPSDT (if under 21)   |
| <input type="checkbox"/> Medicaid Acquired Brain Injury | <input type="checkbox"/> Medicaid Home & Community Based Waiver                               |
| <input type="checkbox"/> Supported Employment           | <input type="checkbox"/> Mental Health Counseling or Medication for a mental health condition |
| <input type="checkbox"/> Home Health                    | <input type="checkbox"/> In home Support  |
| <input type="checkbox"/> Other Medicaid Services        | <input type="checkbox"/> Residential  |
| <input type="checkbox"/> Day Program                    | <input type="checkbox"/> Respite  |
| <input type="checkbox"/> School                         | <input type="checkbox"/> Occupational Therapy   |
| <input type="checkbox"/> Behavior Support               | <input type="checkbox"/> Support Coordinator  |
| <input type="checkbox"/> Transportation                 | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Speech Therapy                 |   |
| <input type="checkbox"/> Physical Therapy               |   |

13. What services are needed now or in the future?

- |   |   |
|---|---|
| <input type="checkbox"/> Day Program      | <input type="checkbox"/> In home Support      |
| <input type="checkbox"/> School           | <input type="checkbox"/> Residential          |
| <input type="checkbox"/> Respite          | <input type="checkbox"/> Behavior Support     |
| <input type="checkbox"/> Transportation   | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy   | <input type="checkbox"/> Support Coordinator  |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Other            |   |

14. The following are 5 choices for future living arrangements. Where would the individual currently on the waiting list prefer to live in the future? (Choose only one)

- At home with a family member with some one to come in and help
- In the person's own home with minimal supports
- In a 24 hour staffed residence in the community
- In a 24 hour supervised family home in the community
- In an ICF/MR

15. Who is the primary caregiver?

- Mother     Father     Grandmother     Grandfather     Aunt     Uncle  
 Sister     Brother     Friend     Neighbor     Other: Who? \_\_\_\_\_

16. What is the age of the primary caregiver?

- Less than 30 years old     31-50 years old     51-60 years old     61-70 years old  
 71-80 years old     Over 80 years old

17. The primary caregiver's health status could be classified as:

- Poor     Stable     Very Good

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person Completing Application: \_\_\_\_\_

Print Name

\_\_\_\_\_  
Relationship to Individual (if not individual)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_