Name: Record Number:

Johnston County Mental Health Center
I/DD Waiting List Assessment

Date: _____

I. BACKGROUND INFORMATION:

Name:
Last First Middle Maiden (if applicable)

Address: _____
Street P. O. Box

City State Zip Code County

Telephone #: _____

Date of Birth: _____ Nickname or other preferred name: _____

Sex: ___Female __ Male *Marital Status:* _ Single _ Married _ Divorced *Primary Language:* _____ _ English _ Spanish _ Sign Other:

Referral Source: _____ Phone #: _____
Who referred individual (parent, psychologist, case mgr., teacher, etc.) ? Please give name and title.

Legal Guardian/Legally Responsible Person:

Address: _____
Last First Middle

_____
(If different from applicant) Street City State Zip Code

_____
Phone #'s: Home: Work: Cell:

V	TYPE OF GUARDIANSHIP	DATE OF ADJUDICATION
	Parent of a minor	N/A for Parent of a Minor
	Guardian of the Person	
	Guardian of the Estate	
	Limited Guardianship (please specify)	

If different from guardian/legally responsible person above, complete the following:

Mother _____
Last First Maiden Address (if different from the applicant)

Father _____ . _____ _ ^
Last First Middle Address (if different from the applicant)

Has individual ever received services through the Area Mental Health, Developmental Disabilities and Substance Abuse Program?

_Yes _No If Yes, please give the dates: From: _____ To: _____

Please list specific services previously received if applicable:

Name: Record Number:

II. DISABILITIES/CURRENT SERVICES AND SUPPORTS:

Diagnostic Information *(check ALL that apply)*

Mild Mental Retardation	Attention Deficit/Hyperactivity Disorder	Autism
Moderate Mental Retardation	Developmental Delay	Seizure Disorder
Severe Mental Retardation	Cerebral Palsy	Traumatic Brain Injury Date of Injury: _____
Profound Mental Retardation	Down Syndrome	Mental Illness (specify diagnosis):
Unspecified Mental Retardation	Learning Disability	
Other (please specify)_____		

*****ATTACH MOST RECENT PSYCHOLOGICAL EVALUATION AND ANY AVAILABLE MEDICAL RECORDS THA T DOCUMENT DIAGNOSIS.***

Where the person lives:

_ At home with biological family including: __mother __ father _ sisters/brothers-how many:
Other: __ grandparent __ Aunt/Uncle ____ Other Relative_____
(Specify)

__ Foster family including: __ foster mother _ foster father sisters/brothers-how many:

_ Group home. Number of others living in-group home: _____

_ State ICF-MR _ Community ICF-MR _ Other:_____

**ARE YOU REQUESTING ASSISTANCE IN FINDING GROUP HOME PLACEMENT NOW? Yes No

(Specify) **Services and Supports the person receives <u>NOW</u> (include school, work, residential supports, family and friend supports):**

__ School Name: _____Grade (if applicable): _____

Special services received at school: _____

Vocational or work placement. Name:

_ Specialized therapies:____PT ____ST ____OT ___ Psychology ___ Nursing ___ Recreation____Dietary

__ Other: _____

_ Other supports ***(complete below)*** CURRENTLY received by individual from programs, family and friends:

V	Person or Provider	Services/Help Received	Contact Person	Phone Number
	CAP-C			
	CAP-DA			
	Medicaid Personal Care			
	Medicaid funded diapers			
	State Funded Respite			
	Tri-Care Specialized Services			
	Vocational Rehabilitation			
	TEACCH			
	ADVP or Other Day Program			
	Psychological			
	Family			
	Friends			
	Other:			

Name:

Record Number:

III. Tell Us About The Person's Special Needs:

Communication: Expressive:
(Check ONE ONLY)

1. Speaks clearly for age. Makes needs known.
2. Speaks clearly but has difficulty making needs known.
3. Speech is not clear, but can be understood by those who know the person.
4. Uses other communication to speak such as gestures or sign language. Makes needs and thoughts known through gestures or signs.
5. Uses some signs but does not communicate basic needs and thoughts.
6. Uses augmentative communication such as pictures or an electronic system (communication board) to communicate basic needs and thoughts.
7. Uses augmentative communication, but has limited expression.
8. Does not intentionally express self consistently through speech, signs, pictures, or communication board

Receptive: (Check ONE ONLY)

1._ Understands most spoken language.
2. Understands only some spoken language.
3. Understands little spoken language.
4. Understands only through gestures, signs, and/or pictures.
5. Responds to speech or sounds but does not understand meaning of words.
6. Does not respond consistently to speech or sounds,

Behavior: (Check ALL that apply)

Child (ages 0-17)

1. Tantrums. How often?
2. Usually follows directions given by adults
3. Rarely follows directions given by adults
4. Hits others. How often?
5. Uses objects as weapons. How often? _____
6. Unable to control anger. What does he/she do?

7. Unusual fears. What are they?

8. Inappropriate sexual behavior? What does he/she do?

9. Is medication given for behavior or attention deficit disorder? Name of medicine:

10. Behavior program or behavior guidelines are in place. Does this help?
11. Wanders or runs away? Explain._____

!2. Self-Injurious behavior? Describe and frequency:

13. Destroys Property? Describe and give frequency:

Adult (ages 18 and up)

1 Cooperative and usually follows rules, appropriate instructions and directions.
2._ Only occasionally follows rules and instructions even though he/she understands the rules/instructions.
3. Temper outbursts without physical violence. How often?_____ _____
4. _ Temper outbursts with physical violence. How often? _____
5. Hitting or assaulting others. How often? _____
6. Uses objects as weapons? How often?
7. Inappropriate sexual behavior. How often? _____ Define behaviors:

8. Medication is given for behavior or psychiatric disorders. Name of medicine(s):

9. Behavior program or behavior supports are in place. Is it working?
10. Wanders or runs away? Explain.:
11. Self-Injurious behavior? Describe and give frequency:

12. Destroys Property? Describe and give frequency: __

Name: Record Number:

IV. MEDICAL AND RELATED NEEDS:

Medical needs requiring family or caregiver support: (Check ONE ONLY)

1. _____Medical needs are routine for age (i.e. annual physicals, regular check ups for children.)
2. _____ The individual has frequent illnesses and goes to the doctor often. Types of illnesses (Please list):

---

3. The individual has medical conditions which require caretakers to perform special tasks at home to take care of him/her. These tasks are:

Please check as applicable:

_ The primary caretaker is able to perform these special tasks without problems.

The primary caretaker is having difficulty performing these special tasks because:

---

4. Individual has been hospitalized frequently. Reasons for hospitalization/s:

Caretaker receives outside assistance in providing medical care for the individual. Assistance is provided by:

___ other family members
___ friends
___ paid staff
nurses

LIST CURRENT MEDICATIONS (list additional medications on back if necessary)	
Name of Medication	***Symptoms/Reason Taken For***

Does the person need help with taking their medicine? D Yes D No

Seizures Yes No	Seizure Type	Frequency

Height Ft: Inches:

Weight Lbs.

Vision	Corrective lenses: Yes No	
Hearing	Hearing Aides: Yes No	

Please list additional medical issues/concerns including needed medical supplies/equipment.

Please list any known allergies:

Specialized Therapies:

_Specialized therapies are needed to enhance development or medical status. Therapies **NEEDED** *(NOT CURRENTLY RECEIVING):*

_PT ____OT____Psychology ____Dietary ___ Recreation ___Speech____ Nursing
Other:

Name: Record Number:

Am**bulation (Mobility-ability to move around or walk). Check ONE ONLY.**

Normal for age

Partially Ambulatory (walks with assistance from ____braces __ crutches___walker or___other adaptive equipment).

Non Ambulatory-Mobile (moves around with assistance from adaptive equipment such as a wheelchair).

Non Ambulatory-Non-Mobile (unable to move from place to place without assistance from others. Requires total assistance from others to use adaptive equipment),

V. SELF HELP AND PERSONAL CARE:

Self-Help/Self-Care Pressing:
(Check ONE ONLY)

Dresses self appropriately for age

Dresses/undresses self with verbal reminders (including selecting appropriate clothing for season, occasion, etc).

Assistance with dressing/undressing needed (including help with fasteners). More assistance than usual for age.

Requires total assistance with dressing and undressing. Depends on others for this support.

Toileting: (Check ONE ONLY)

Toilets independently for age.

Toilets with occasional reminders and assistance (not expected for age).

Requires prompting and/or physical assistance for toileting on a consistent basis (assistance not usual for age).

Full assistance for toileting or not toilet trained (expectation that person should be toilet trained at current age),

Eating: (Check ONE ONLY)

Eats independently for age

Eats independently, but has poor use of utensils, is messy for age.

Eats with assistance from others. Not expected for age.

Depends on others to be fed. Not expected for age.

Tube Feeding is required

Bathing: (Check ONE ONLY)

Bathes self independently for age.

Needs verbal instructions or reminders and should be independent for age.

Needs physical assistance and should be independent for age.

Total Assistance required for bathing and should be independent for age.

VI. Accessing the Environment:

1. **Access to familiar indoor environments: (Check ONE ONLY)**

With or without adaptive devices, the individual moves around in a familiar environment without assistance (home, classroom, work environment).

The individual requires assistance (verbal or physical) to move around in familiar environment due to physical, behavioral, or cognitive disabilities.

2. **Access to familiar outdoor environments: (Check ONE ONLY)**

The individual independently for age, accesses familiar locations in his environment (back yard, next door neighbors, walks to store, bus stop, etc.).

The individual requires greater monitoring and assistance than a non-disabled individual of the same age, to access familiar locations in his environment such as the back yard, neighbors, local store, etc due to physical, behavioral or cognitive deficits.

VII. Use of Items in the Environment:

1. **Use of items in environment:**

The individual uses/operates familiar items of interest/need appropriately for age, with minimal assistance (telephone, television, eating utensils, toys, brush, comb, etc)

The individual requires assistance from another person to use items of interest/need due to physical, behavioral or general cognitive problems.

2. **Ability to self entertain and enjoy items in the environment:**

The individual interacts independently for age with common items of interest for age for entertainment (movies, games, toys).

The individual requires assistance to use items for pleasure or entertainment. Items must be selected by others or others must facilitate interaction due to physical, behavioral, or cognitive impairments of the individual.

Name: Record Number:

VIII. Adaptive Equipment and Supported Protective Devices (Please check one below):

-Individual does not need adaptive equipment.

-Individual has or needs equipment. Complete Below:

(Check Has or Needs for ALL that apply)

Has	Needs	Adaptive Equipment	Has	Needs	Adaptive Equipment
		Wheelchair			Supportive Belts
		Walker Crutches Braces			Bedrails
		Hearing Aid			Lap Tray
		Glasses			Modified Shoes
		Adaptive Clothing			Mittens Splints
		Adaptive Utensils			Helmet
		Augmentative Comm. Device			Other:

What type of future adaptations may be needed?

IX. SOCIAL INTERACTIONS:

Check ONE ONLY:

1. The individual initiates/interacts with others in a manner generally appropriate for his/her age.
2. Initiates/interacts with others in a manner more typical of a younger child.
3. Social interactions skills are limited. Explain:_____

4. Does not understand social interactions initiated by others (greetings, etc) or responds inconsistently or inappropriately. Requires assistance to facilitate social interaction (due to physical or cognitive limitations) re-direction for inappropriate interactions.

Check ONE ONLY:

1. Generally demonstrates appropriate (for age) physical contact for situation (handshake, hug, kiss, etc)
2. Requires verbal or physical reminders or intervention to ensure appropriate type of physical contact for situation due to physical, behavioral, or cognitive limitations.
3. Physical contact is often inappropriate for age (touching, hitting, biting, etc) requiring supervision to prevent such behavior.
4. The individual displays inappropriate sexual contact. Explain: _____

X. HEALTH AND SAFETY:

Safety with common objects (understanding danger with objects). Check ONE ONLY:

1. Within familiar environment (home, school, group home, work, etc), the individual recognizes danger in the form of items (hot, sharp, non-edible) and responds appropriately for age.
2. Within familiar environment (home, school, work, etc), the individual requires greater monitoring than a non-disabled person of the same age with common objects (hot, sharp, non-edible).

Understanding of Dangerous Situations. Check ONE ONLY:

1. Within familiar environment (home, school, group home, work, etc), the individual recognizes dangerous situations such as traffic, bodies of water, fire, etc.) and responds appropriately for age.
2. When compared to individual of the same age, the person appropriately (for age) requests assistance with danger (calls for help, could state name if lost, etc).
3. Individual requires monitoring and supervision in proximity to danger (i.e. traffic, water, etc.). This supervision is more than would be provided for a non-disabled person of the same age.

Name: Record Number:

Night Supervision Requirements (PLEASE CHECK AS APPLICABLE):

1. Adult: Individual can remain alone in a residence at night without supervision.
2. Adult: Individual requires access to supervision during the night.
3. Adult or child: Individual requires frequent intervention during the night due to sleep disorders, behavioral, physical or other medical needs.
4. Adult or child: Individual requires awake supervision during the night to maintain health and safety due to sleep disorders, behavioral, physical or other medical needs.
5. Child: Individual does not require awake supervision and sleeps through the night.

XI. SERVICE NEEDS:

Please check all that apply.

Hourly Support Services			
	Home and Community Supports (training provided in the home & community)		Personal Care (assistance with bathing, dressing, eating, etc.; monitoring; non-training support)
	Respite (provides periodic relief for primary caregiver)		Day Supports (training provided in licensed day facility)
	Crisis Services (one additional support person during acute crisis situations)		Individual/Caregiver Training & Education (specialized education and training, as needed, for individual and/or family to enhance overall care)
	Specialized Consultative Services (provides expertise, training, and technical assistance from a consultant in a specialty area)		Supported Employment (activities needed to sustain paid work by individuals receiving waiver services including supervision and training)
	Other:		
Daily Support Services			
	Residential Supports (training and/or personal care provided for individuals living in residential placement such as a group home, AFL, etc.)		
	Other:		

How would these services help the person?

How would they help his/her family or significant others?

XII. Special Circumstances That May Impact Needs and/or Service Delivery:

Name: Record Number:

XIII. Other Service Considerations and Referrals: ***(IMPORTANT/PLEASE COMPLETE)***

What other referrals have been made or considered?

	Service	Referral Made (Date)	Disposition (On Wait List, Appt. Made, No Services Available, etc.)
	CAP-C		
	CAP-DA		
	Medicaid Personal Care		
	Group Home placement		
	Vocational Rehabilitation		
	Tri-Care Specialized Services		
	ADVP or Other Day Program Name of Prog.		
	Psychological		
	TEACCH		
	Other:		

If no other services have been considered or referrals made, please explain why:

XIV. Financial and Insurance Information. Check ALL that apply:

__SS Monthly Amount
_ S A Monthly Amount
_ Other- Specify:
__Trusts/Reserves/Funds in Consumer's name exceed $2,000, Monthly Amount:

Medicare: Are you currently receiving Medicare: D Yes D No
Medicare #: _____ Effective Date:
Consumer's name AS IT APPEARS on the Medicare card: ___
Are you eligible for coverage under the Veteran's Administration? D Yes D No
Are you disabled and receiving Social Security benefits? D Yes D No

Medicaid: Are you currently receiving Medicaid? D Yes D No
Medicaid #: _____
Consumer's name AS IT APPEARS on the Medicaid card: _____
Most recent Medicaid effective dates: From: _____ To: ___
Please indicate color of Medicaid card: D Buff D Blue

Is the consumer currently covered by private insurance? D Yes DNo
If yes, please list insurance information below:
Insurance Company: _____
Insured Party: _____ Group #:
Individual #: _____ Policy #:
Claims Address: _____

Telephone #: Effective Date of Insurance:

Name: Record Number:

XIV. Person Completing I/DD Waiting List Assessment;

Name: _____

Relationship: _____

Date: _____

Assistance in completing this application was provided by:

Name: _____

Relationship/Agency: _____

Consumer/Family keeps this page for informational purposes!

CAP-MR/DD Waiting List Procedure

For tracking of persons determined to be "waiting" for services, the following procedure has been established for CAP-MR/DD Waiver funded services.

An individual cannot be placed on the CAP-MR/DD waiting list until their referral is complete. A completed referral includes the completion of the I/DD Waiting List Assessment, submission of the most recent Psychological Evaluation that includes both a cognitive and adaptive behavior assessment and submission of any clarifying information requested by the LME DD Services Manager in determining appropriateness for CAP-MR/DD funding. Placement on the CAP-MR/DD waiting list *does* ***not*** *guarantee* services will be funded. Funding for services is based on availability of funds. As funds become available, slot allocation is based upon acuity of need. The final decision for funding is based on Murdoch Center's determination that ICF-MR level of care criteria has been met. The criteria for ICF-MR level of care (see pages 6-8 of CAP-MR/DD Manual) requires: mental retardation or similar diagnosis resulting in substantial functional limitations in 3 or more areas of major life activity (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living). Slot allocations for CAP-MR/DD funding do not occur on a consistent basis; therefore, it is not possible for LME staff to provide an estimated time that someone may wait for this funding.

Signature:_____ Date: _____

LME Representative/Title