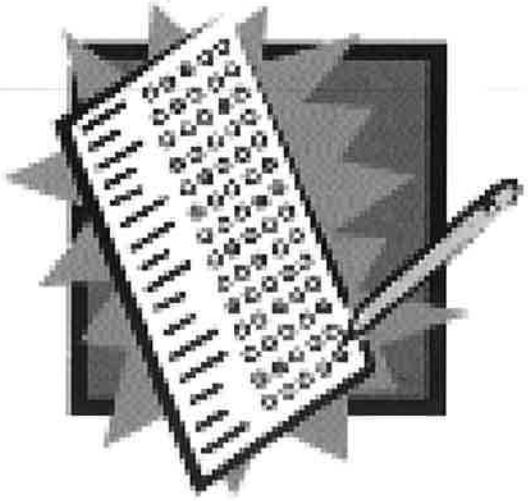
Level of Need Assessment and Screening Tool Manual



LON

November 2011

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services

Effective Date: November 14, 2011	Number of Attachments: 0
Responsible Office: DDS Deputy Director, Developmental Disabilities Administration	
Supersedes Policy: N/A	
Title/Subject: **ICF/IDD Level of Care Determination**	
Cross-References: Individual Service Plan Policy and Procedure; HCBS Waiver Application Process; Level of Need Assessment and Screening Tool Policy and Procedure	

1. PURPOSE

The purpose of this policy is to introduce the use of a comprehensive and uniform assessment tool to provide uniform information upon which the District will make Level of Care determination decisions for eligibility for participation in the ICF/IDD and ID/DD Home and Community-Based Services Waiver programs.

2. APPLICABILITY

This policy applies to all DDA employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of individuals with disabilities receiving services as part of the DDA Service Delivery System funded by DDA or the Department of Health Care Finance (DHCF).

3. AUTHORITY

Department on Disability Services as set forth in D.C. Law 16-264, the "Department on Disability Services Establishment Act of 2006," effective March 14, 2007, (D.C. Official Code § 7-761.01 *et seq.*); and D.C. Law 2-137, the "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978," effective March 3, 1979 (D.C. Official Code § 7-1301.01 *et seq.*).

4. POLICY

All persons requesting services through the Department on Disability Services (DDS) provided in an Intermediate Care Facility for individuals with Intellectual and Developmental Disabilities (ICF/IDD) home or through the DD Medicaid Home and Community-Based Services (HCBS) waiver program must have an ICF/IDD level of care determination completed to determine eligibility for the program. A level of care re-determination must be conducted on an annual basis to recertify on-going eligibility for participation in the Medicaid program.

5. RESPONSIBILITY

The responsibility for this policy is vested in the Director, Department on Disability Services. Implementation for this policy is the responsibility of the Deputy Director, Developmental Disabilities Administration

6. CRITERIA:

Per Title 29 DCMR, Section 1902.4, an individual meets the level of care determination if one of the following criteria has been met:

(a) The individual's primary disability is intellectual disability with an intelligence quotient (IQ) of 59 or less;

(b) The individual's primary disability is intellectual disability with an IQ of 60-69 and the individual has at least one of the following additional conditions:

1. Mobility deficits;
2. Sensory deficits;
3. Chronic health needs;
4. Behavior challenges;
5. Autism;
6. Cerebral Palsy;
7. Epilepsy; or
8. Spina Bifida.

(c) The individuals' primary disability is intellectual disability with an IQ of 60-69 and the individual has severe functional limitations in at least three of the following major life activities:

1. Self-care;
2. Understanding and use of language;
3. Functional academics;
4. Social Skills;
5. Mobility;
6. Self-direction;
7. Capacity for independent living;, or
8. Health and Safety.

(d) The individual has an intellectual disability, has severe functional limitations in at least three of the major life activities set forth in (c) 1-8, and has one of the following diagnoses: autism, cerebral palsy, prader willi or spina bifada.

7. STANDARDS:

The following are the standards by which DDS will evaluate compliance with this policy:

1) Individuals who are found eligible for services from DDS's Developmental Disabilities Administration (DDA) are individuals who have been determined to have a diagnosis of an intellectual disability.

2) The DDA Intake and Eligibility Determination Unit obtains age-appropriate psychological evaluations during the eligibility determination process that includes the individual's IQ.

3) The DC Level of Need Assessment and Screening Tool (DC LON) is a comprehensive assessment tool, which documents an individual's health, developmental and mental health diagnoses, and support needs in all major life activities to determine the level of care determination criteria specified in (b) 1-8 and (c) 1-8 above.

4) The DDA Intake and Eligibility Determination Unit Service Coordinator will complete the DC LON based on information obtained in the DDA Intake application, medical examination, social work history, psychological evaluation, school records, vocational assessments, and/or other available background information and interviews. The DC LON also provides an assessment of the individual's functional developmental, behavioral, social, health and nutritional needs, which is required by an ICF/IDD program to determine if admission to that specific program is appropriate.

5) The "additional conditions" specified in the level of care determination criteria in (b) 2,3,5,6,7,8 are found in the DC LON at questions 15 and 16. The criteria for (b) 1 is considered met if the individual receives a score of 2 or higher on the Mobility scale in the DC LON Summary Report, and (b) 4 is considered met if the individual receives a score of 2 or higher on the PICA, Behavior or Psychiatric scale in the DC Lon Summary Report.

6) The criteria for severe functional limitations in the following major life activities specified in the level of care criteria in (c) is considered met by the following scores in the DC LON Summary Report:

a) Self-care - Score of 3 (out of 8) or higher in Personal Care
b) Understanding and use of language- Score of 2 (out of 4) or higher in Communication
c) Functional academics- refer to the Psychological evaluation
d) Social Skills- Score of 3 (out of 7) or higher in Social Life
e) Mobility- Score of 2 (out of 7) or higher in Mobility
f) Self-direction-Score of 1 (out of 3) or higher in Comprehension and Understanding

g) Capacity for independent living-Score of 2 (out of 6) or higher in Daily Living
h) Health and Safety- Score of 2 (out of 7 or higher) in Health or 2 (out of 7) or higher in Safety

7) When a person served by DDA has chosen and is accepted by an ICF/IDD program, DDA will submit the medical evaluation, psychological evaluation, the DC LON and the DC LON Summary Report, along with Form 1728 to Delmarva to complete the ICF/IDD level of care determination.

8) If the person seeking supports has chosen to receive services through the ID/DD Home and HCBS waiver program, the DDA Service Coordinator submits the waiver application package, inclusive of the medical evaluation, psychological evaluation, DC LON and Summary Report, to the DDA Waiver Unit. The DDA Waiver Unit completes the initial level of care determination as part of the eligibility review for the ID/DD waiver program.

9) The staff qualifications to make a level of care determination are either QDDP qualified or a licensed Registered Nurse.

10) The level of care must be re-determined on an annual basis per 42 CFR 441.302 (c)(2) for the ICF/ID program and the approved DC ID/DD HCBS waiver. The DC LON is completed prior to the team's review of the Individual Service Plan and will be utilized to re-determine the level of care criteria.

11) For persons receiving services in an ICF/IDD program, the ICF/IDD provider is responsible for submitting the completed DC LON and Summary Report, the continued stay Recertification Form completed in its entirety and the physician's certification and recertification for skilled and intermediate care form dated with the physician's signature to DHCF for the re-determination for the ICF/IDD program.

12) For persons enrolled in the DD HCBS waiver program, the DDA Service Coordinator completes the level of care re-determination as part of the annual review and update of the Individual Service Plan.

13) The DDA Waiver Unit verifies the level of care re-determination has been completed prior to authorizing the new waiver Plan of Care.

Laura L. Nuss, Director

11/14/2011
Approval Date

Introduction

The design, testing and development of this assessment tool has been supported by a CMS Systems Change Grant in Connecticut under the guidance of a volunteer Steering Committee representing various stakeholders, and completed by a research team from the UCONN Health Center. This assessment provides the information needed to accomplish the following objectives:

- determine an individual's need for supports in an equitable and consistent manner for the purposes of allocating DDS resources
- identify potential risks that could affect the health and safety of the individual, and support the development of a comprehensive Individual Plan to address potential risks
- identify areas of support that may need to be addressed to assist the individual in actualizing personal preferences and goals

This assessment is to be completed or reviewed as part of the Individual Service Plan (ISP) process on an annual basis for individual's who are receiving DDS funded services. It should also be completed when submitting a request for services if one has not been completed within the previous 12 months, as part of the initial transition planning for high school students at the age of 18 or upon determination of eligibility prior to transfer to continuing services.

This manual has been produced to assist the service coordinators in completing the Level of Need (LON) assessment. It is suggested that service coordinators review the guide and use it as a reference when completing the assessment or assisting the individual and members of the team to understand the LON process.

The Level of Need Assessment and Screening Tool has been in use since April 2006 in CT. This version of the Tool and Manual (1.02) has been updated using the findings from the first 12 months of use as part of the CMS Grant Project. Any questions regarding the assessment or this manual should be referred to your service coordinator supervisor.

Table of Contents

General instructions:

1. Answer every question on each page completely, including the person's identification information on the first page.

2. Mark only one box per item, unless specifically stated to do otherwise. If a person falls in between two categories, the service coordinator in consultation with team members must decide which category best describes what is typical for the person, or how much support he/she usually requires for that item. If the service coordinator is not sure which box to check, ask someone else who knows the person well or refer to his/her current written record. The service coordinator filling out the form may also need to use his/her best professional judgment to choose the box which most closely reflects the person's abilities and support needs. Any additional clarifying comments or explanations may be included in the comments box at the end of each section or at the end of the form.

   Example:

   Kayla often refuses to get dressed, and yells at staff members when they assist her with dressing in the morning. Usually the staff are able to distract Kayla by talking about the day's activities. However, one person hands-on support is needed a few times a year to finish the task. In this case, the LON would reflect what support is typically required (Verbal or gestural distraction or prompting), even though this is not always the case.

3. Indicate how much support or assistance the person truly requires or needs, either for the management of a behavioral or health condition or to successfully complete a task or activity. This may or may not be the same as how much support or assistance the person is currently receiving.

   José lives in a licensed residential habilitation (RH) group home. José's support needs do not require a staff person to be awake throughout the night, but he does require someone in his residence who can be sleeping in case he needs assistance in the night. However, the RH requires that a staff person be awake throughout the night. In this case, the LON should reflect what support José truly requires (Needs a person in his residence who can be sleeping) versus what the group home provides for everyone.

4. The LON is to reflect the person's current support needs, that is, support typically needed in the past 3 to 6 months. Unless specifically asked to do otherwise, the team should only consider the person's current support needs when completing the LON. One exception to this would be for those youth transitioning from high school to day/vocational services within the next year. For these young people, consider their support needs after graduation for work or day activities when completing the form.

5. For any activities the person does not do in their daily life, consider how much support the person would need if they were to successfully complete the activity. This may require the team completing the LON to reflect on the person's total skill level, other activities the person currently does, or the statements of others who know the person well.

   Nicole has lived with her parents all her life. Her mother continues to do the housework for the household as she has always done. In this case, Nicole does not do any

household chores on a regular basis. However, when asked, her mother does say that Nicole has used the washing machine and occasionally helps her to do other household chores, although she needs to keep an eye on Nicole in case she gets distracted. In this case, the LON should reflect how much support Nicole would need if she were to do her own household chores (Does household chores with prompting, monitoring, instruction, or encouragement), versus choosing the third category (Cannot complete household chores).

6. The word "typically" is used throughout the survey to indicate what happens most often, on average, or what is usual for the person. While there is variation in everyone's activities and daily lives, most of us can identify what usually happens or what we do most often. If asked to consider a certain time period (such as "in the past year"), the team may need to determine the average number of times the item occurred in this time period to find out how often it typically happens. The team should then mark the best choice, knowing that it may not be exactly right. Any qualifying remarks can be included in the comments box at the end of the section or form.

   Kevin had two grand mal seizures in March, one aura in June, and another grand mal seizure in December. The question asks the team to determine how many grand mal or convulsive seizures Kevin had in the past year. To do so, the team would need to add up the total number of qualifying seizures in the past year (three) and divide by the number of months (12). In this case, Kevin's rate of grand mal seizures would average out to less than one seizure a month.

   Even if there has been a recent increase or decrease in the number of occurrences, the same method is used to determine the average number of times any event occurred in the specified time period.

   Kevin had two grand mal seizures each month *in February, March, April and May, but had none in the previous eight months. The calculation of the average number of grand mal seizures per month over the past year would remain the same. In this case, when completing his LON in May, Kevin had a total of eight grand mal seizures within the past 12 months, or less than one a month. <u>However</u>, you would use the comments box at the end of that section to report the new pattern that has now emerged, two per month.*

7. Some items will specifically ask for a description of the circumstances surrounding the skill, behavior or health condition, or to fill in the blank. Please read all the items carefully, and if a description is asked for, provide a brief explanation of the circumstances in the comments box at the end of that section.

8. Some of the questions refer to "home or residence" and "day, school, or vocational program." If a person is employed or earning income, his/her employment activities would fall under the day, school, or vocational category. However, if a person's day program takes place at his/her place of residence, his/her day program would be included in the "home or residence" category.

9. Examples are often used to further describe an item. They are shown in parentheses (as in Question 15) or following the words such as, including, or for example (as in many of the Daily Living activities or Safety questions). These are used for explanatory reasons only, and should not be seen as an exhaustive list. For example, in question 16, Rheumatoid arthritis, multiple sclerosis, and lupus are listed as examples of auto immune disorders. These examples are not meant to exclude other auto immune

disorders, such as Graves' disease or amyotrophic lateral sclerosis – Lou Gehrig's disease. Examples are also specifically given in the manual, following statements such as "examples include," "such as," or "for example." Once again, these are given only as explanations, and should not be seen as an exhaustive list.

10. The questions are written to be as self-explanatory as possible, with definitions and qualifying statements built into the questions. In addition, a more detailed explanation is provided for some of the items below.

Health and Medical

Questions 1 - 10

Prescribed treatment or care includes a list of ten different medical procedures, treatments or conditions. Check "Yes" if the treatment or care is currently prescribed for and used by the person; "No" if it is not. Then fill in how often assistance is needed with the treatment (support frequency) and who most often provides this care (support provider) for each Yes response.

The LON should reflect what typically or usually is needed. For example, if a person regularly gets an injection once a day, but once every two or three months also requires a second injection later in the day, the answer should reflect what usually is required or what is needed most often (in this case, once a day). Any qualifying comments should be written in the comments box at the end of the section.

Support Frequency refers to how often care or assistance is typically needed for each procedure or treatment. The descriptions given after each procedure give guidelines as to what should be considered when determining support frequency. For treatments which are not used continuously (such as a needle injection or postural drainage), support frequency, or the care or assistance needed for this procedure, refers to how often the procedure is given. If a procedure is used continuously, such as an ostomy bag, support frequency refers to the amount of care associated with the procedure, such as the care and monitoring of the bag, rather than the fact that the person always uses one.

Support Provider refers to the category of person who typically or most often provides this treatment. Examples of unlicensed direct care staff (Code 6) include, but are not limited to: personal care assistants, certified nursing assistants, Direct Support Professionals (DSP), or host home providers. Code 7, family member or friend, may be thought of broadly to include any non-medically licensed person who is unpaid, such as a partner, neighbor, or church member.

If certain medical treatment or care has been delegated to a family member by a licensed medical professional, and the family member usually provides the delegated treatment, code the support provider a 6 (family member or friend). Then write in the Health and Medical comments box that this treatment is delegated to a family member by a medical professional. Question 11 also takes this into account.

> *Matt has a tracheostomy and needs postural drainage by a physical therapist three times a week. He always breathes through his tracheostomy, and his mother cleans around the stoma once a day. In this case, support frequency for the tracheostomy would be once a day, and a 4 written in that line. Support provider would be "family member or friend," and a 7 would be written in that line. For the postural drainage, support frequency would be a 3, or several times a week, while support provider would be a 4 for physical therapist, as the physical therapist usually provides this treatment.*

Question 11

Question 11 only applies if a family member is the primary provider for at least one of the treatments in questions 1 – 10. Check "Yes" if in the absence of this family member, the treatment or care is provided by medically licensed personnel (for example, an LPN, occupational therapist, physical therapist, etc.). Check "No" if in the absence of the family member primary provider, the treatment or care is provided by someone who is not medically licensed (for example, a Host Home provider, a personal assistant, certified nursing assistant, friend, neighbor, other family member, etc.).

If a family member is not the primary provider for any of the treatments/care in questions 1 – 10, then "Not applicable" should be checked. If the person does not receive any of the treatments in questions 1 – 10, check "Not applicable" as well.

Question 12

***Hands on or direct care* from a nurse** refers only to hands on or direct care the person requires or needs from a licensed nurse, such as an RN or LPN. Hands on or direct care refers to medically necessary care performed either at the person's residence, school, day/vocational program or work, but not in a medical setting such as a doctor's office, clinic, or hospital. This includes situations where the direct care person must be an RN or LPN due to the person's medical condition which requires that level of expertise to monitor a condition and make decisions regarding interventions. This does not include routine assessments, incident monitoring, medication administration (MAR) review, blood drawing, etc. If no hands on or direct care by a nurse is required by the person, then mark question 12 a "No," and skip to question 14.

> *Tammy lives in a RH group home with five other residents. A nurse comes once a month to review her care and do a monthly assessment for her, as well as the other five residents in the RH. As Tammy is not receiving any direct, hands on care from the nurse, "No" would*

be checked for question 12. The person should then skip to question 14, leaving question 13 blank.

Question 13a

To answer how often this hands on or direct nursing care is needed, consider the past 3 – 6 months only. Then mark the choice which best describes how often the person requires hands on care from a nurse over the past 3 – 6 months. Refer to number six in the general instructions for guidance on how to determine which choice to mark. If question 12 is marked "No," then leave questions 13a and 13b blank.

Question 13b

Refer first to question 13a. If "At least once a day" is checked for question 13a, then check the box in question 13b which best reflects the typical number of hours of hands on nursing care needed by this person for the past 3 – 6 months. If continuous, 24 hour direct nursing care is chosen, an explanation must be included in the health and medical comments box as to why it is needed.

If direct nursing care is not needed every day, then check the first choice in 13b ("Direct nursing care is not needed every day").

Question 14

Only grand mal or convulsive seizures in the past 12 months are to be considered in this question. If the person has had any other type of seizure activity, but no grand mal or convulsive seizures in the past year, check the first box: None in past year. The first box would also be checked for a person with a seizure disorder or epilepsy who has had no seizures at all in the past year. If the person has never had any type of seizure, check the last box: N/A – Has never had a seizure. Please note that question 16 will record any diagnosis of epilepsy or seizure disorder.

Question 15

Developmental disability diagnoses include a wide range of health, chromosomal, intellectual, and physical conditions or impairments which begin before age 22 and are expected to continue indefinitely. For any developmental diagnosis not on the list, check the "Other" box and write in the developmental diagnosis in the space provided.

Question 16

Only health or medical conditions diagnosed by a licensed medical professional may be included or checked in this section. Substance abuse would be the one exception, as this is often diagnosed by a non-medical professional, such as a licensed social worker or psychologist. Although any drug or medication can be misused, substance abuse refers to the misuse of legal or illegal drugs with a high potential for addiction, such as alcohol, sedatives, narcotics, stimulants, psychedelics, inhalants, marijuana, and nicotine. Any diagnosed medical conditions not on this list are to be written in the spaces provided. The diagnoses written in parentheses are given as examples of conditions falling under the more general diagnosis, and are not meant to be an exhaustive list.

Question 17

Check only those conditions or issues which apply to the person. Leave blank any that do not apply. If none of the conditions apply, check the last item in question 17: None of these apply. A further description of some of the items follows:

Requires food or liquid to be in particular consistency or size includes food size or consistency requirements ordered by a medical professional or reported by the family member if the person is living at home.

Food consistency requirement change within past 3 months is only for very recent (within past 3 months) food consistency requirement changes.

Medically prescribed special diet must be prescribed by a doctor or APRN. It can include diabetic, caloric restriction, or any other medically prescribed special diet.

History or risk of dehydration may be the result of an underlying health condition or a physical or cognitive limitation that makes it difficult for the person to obtain fluids on their own.

History or risk of choking can be caused by a number of factors, including coughing during or after meals, excessive throat clearing during or after meals, or gagging on food or liquids.

Hands on assistance or close supervision required to use stairs within his/her residence – Check this item only if the person requires hands on assistance or close physical proximity supervision (arm's length) to use stairs in his/her residence. Other mobility issues are addressed later in this form.

Tactile kinesthetic issues are sensory difficulties relating to the sense of touch and the feeling of movement, including hypersensitivity to touch or other sensory stimulation such as light or sound.

Medical devices – The medical devices listed are given as examples and are not an exhaustive list. C-PAP machine refers to a sleep apnea machine used while sleeping. Do not include glasses, contacts, or hearing aides.

Question 18

Medical office visits or off-site medical or mental health care only includes visits to a medical facility, office, or emergency room for medical or mental health care. It does not include in-home or in-residence visits, where the medical professional comes to the person's residence, home, day or vocational program to treat or see him/her. Consider only off-site or office visits to a licensed medical or mental health professional such as a doctor (including podiatrist); dentist; nurse; laboratory technician; emergency room; physical, respiratory, or speech therapist; psychiatrist; psychologist; or behavioral therapist.

Question 19

Problems with off-site medical appointments include any issues with respect to the person receiving his/her off-site medical care or seeing his/her off-site doctor or medical professional. Off-site medical care includes care at a medical facility, office, or emergency room, but not in-home or in-residence medical visits. Examples of these issues include problems getting to the office (for example, difficulties with transportation or lack of site to site assistance), refusal of services, inability to locate a health care professional, or lack of support from the person responsible for the individual receiving his/her off-site medical care.

Question 20

Please read carefully. The "Yes" or "No" response only refers to whether a *discharge plan* is in place, not whether a person is hospitalized or not. Question 20 refers to short term or rehabilitative placement only (medical or psychiatric) . If a person is in appropriate long-term placement in a skilled nursing facility or long term care facility, check "Person is not in a hospital/rehab facility" and leave anticipated date of discharge blank.

Question 21

Check only those medication issues or concerns which apply to the person within the past month (unless otherwise stated). Leave blank any that do not apply. If none of these conditions apply in the past month, or if the person does not take any prescribed medications, check the last item in question 21: None of these apply, or does not take any medications. The medications listed in parentheses are given as examples, and should not be considered an exhaustive list. A further description of some of the items follows:

Medication/s require careful monitoring for side effects – Careful monitoring includes the need for more than annual blood tests, or the need for regular clinical oversight in order to monitor for any side effects.

Frequent changes in medications generally refers to two or more changes in medication or dosage within the past 3 months.

Long-term use of a neuroleptic, psychotropic, mood, or behavioral medication – Long term generally refers to 1 year or more.

Personal Care and Daily Living Activities

The description of each personal care and daily living activity should be read carefully, and each of the three to four choices considered before checking the one box which best describes how much support the person typically requires to do that activity. Once again, the evaluator may need to consult with someone who knows the person well, review the person's records, or use his/her best professional judgment in order to check the one box which best reflects the person's abilities for each question. This may especially be true if there is a lack of opportunity for the person to demonstrate his/her abilities in a particular area. For young children, it is recognized that some of the personal care and many of the daily living activities may not be applicable – in this case, check the level of assistance currently needed to complete the activities.

Examples and further descriptions are given for each question and for each answer choice. Once again, these examples are not meant to be used as an exhaustive list, but as a way to give the evaluator a better idea of what activities are covered in each question and in each answer category. Any qualifying comments may be included in the daily living activities comment box.

Special instructions for those people who use tube feeding:

For a person who uses tube feeding and is on a nasogastric, J, or G tube, the last answer would most likely be checked for question 26 (eating). However, the person may or may not be able to chew or swallow, so the most appropriate box for that person should be checked for question 27 (chewing and swallowing). For question 36 (meal preparation), it is most likely that the third answer (requires assistance) would be checked.

Questions 22 - 30

Personal care activities include dressing and undressing, bathing or showering, grooming and personal care, using the toilet, eating, chewing and swallowing, mobility inside the home, transferring, and changing position in a bed or chair.

Eating, chewing and swallowing:

If the team has any concerns in these areas that have not been assessed by a clinical professional, the team should seek a review or consultation by a doctor, or seek advice from a regional clinician such as an occupational therapist, speech therapist, dietician, or health services director.

Questions 31 - 38

Daily living activities include mobility in the community, taking medications, using the telephone, doing household chores, shopping and meal panning, meal preparation and cooking, and budgeting and money management. Please check the one box which best describes how much support the person typically requires to do each activity. Any comments may be included in daily living activities comments box.

The evaluator should use his/her best professional judgment and consult with others who know the person well if any uncertainty or if there is a lack of opportunity for the person to demonstrate his/her abilities for a particular question. As with the rest of the form, this section is assessing the person's abilities to do certain activities, not whether or not he/she does them in their daily life. For example, if a person can vacuum and do laundry independently, but chooses not to, he/she would still have the first answer (Does household chores by self independently) checked, even if he/she is not currently doing them. Many of the daily living activities may not be applicable for young children, and a young child may need complete assistance to do them, such as budgeting money, taking medications, meal preparation, or shopping. In this case, the last answer (needs assistance) would be checked for each one.

Some daily living activities represent a grouping or set of similar activities, such as household chores which may include washing dishes, laundry, and housecleaning. In such cases, the person's overall ability to do all of the typical activities falling under the heading "household chores" should be taken into consideration. Explanations for selective questions are given below:

Question 31

Mobility in the community does not include transportation needs. Transportation is assessed later in the form. Instead, consider how the person ambulates or moves around when out in the community. If the person usually walks in the community on his/her own, but routinely uses a wheelchair when going to the mall or for longer shopping trips, check the second answer, Walks by self, but may require physical support of assistance from another person.

Question 33

Using the telephone, can include either expressive or receptive communication. Thus, even if a person cannot speak, consider the person's ability to use the telephone for listening. For individuals who cannot hear, consider the person's ability to use TTY or relay services.

Question 35

Shopping and meal planning also does not include transportation needs. Instead, think of the person's ability to shop for groceries without considering any possible transportation assistance to get there.

Question 38

Transitioning from and between activities refers to the ease at which people can make such changes without discomfort or resistance due to the change, often associated with challenges related to diagnoses of autism or obsessive compulsive disorders.

Behavior

Behavioral health includes any behaviors or diagnosed emotional conditions requiring monitoring or ***a treatment plan*** in the past year. Questions 39 – 49 refer to specific behaviors which occurred or were addressed by a treatment plan in the past year; questions 50 – 51 refer to two specific behaviors or issues which occurred within the last year; questions 52 – 55 ask about the history of certain behaviors or issues; and questions 56, 57a, and 57b ask about mental health or emotional conditions. Descriptions or examples of each behavior or condition are included in the tool.

General instructions for Behavior section:

Please check "Yes" for any behaviors or diagnosed emotional conditions requiring monitoring or a treatment plan in the past year; otherwise, check "No." For each behavior or condition checked "Yes," consider the type and level of support typically needed to manage the behavior during waking hours. Then fill in the code which best reflects the type and level of support typically required for each behavior. Only one code for type of support required and one code for level of support are to be given for each behavior or condition checked "Yes." *Consider only waking hours type and level of support*; all overnight support and assistance is assessed in a later section of the form. This section should also reflect only that support which is currently needed for behavioral issues; general monitoring or supervision is addressed later in the form.

Consider each behavior and support needs separately for 1) when the person is at his/her home or residence and 2) when the person is at his/her day, school, or vocational program (the latter includes any employment activities). If a person's day program takes place at his/her place of residence, his/her day program would be included in the home or residence category.

Support Required is the type of support typically provided during waking hours ***when this person exhibits this behavior.*** If a treatment plan is actively in place to control a past behavior, the support required would be the waking hours support necessary to keep the behavior controlled. If two different types of support are used, write in the code for the support most frequently provided, and write in any qualifying comments in the behaviors comments box. A higher level of support may include other types of lower levels of support. For example, if Code 2, verbal or gestural distraction or prompting, is typically needed, it may be that monitoring may also be used part of the time. Code 1, monitoring, can also be used if the person's behavior is being controlled by medication or a treatment plan. Hands-on support refers to physical contact needed for support or intervention; in Code 3, it may only be provided by one person. If more than one person is typically required to redirect or manage person, choose Code 4, and explain the situation in the behavior comments box.

To be included, the support required must be specific to the person and their behavioral support needs. For example, monitoring can include monitoring by a person or using environmental means, such as door alarms. *However, to be included here, the monitoring must be used to address a specific behavior on the list exhibited by this person.* For example, if the door alarms are used to monitor the person's wandering behavior, they can be included as a support required for his/her wandering behavior (monitoring).

Support Level indicates the level or intensity of support typically or usually provided during waking hours only. In some cases, it may be easier to think of in terms of frequency of the behavior. Use your best professional judgment to indicate which code best reflects the level of support typically need for each behavior. Support for behavior which is episodic or happens occasionally would be Code 1. Any support which is continuous during waking hours, such as monitoring by use of an environmental device which is always on, or 1: 1 arm's length to prevent PICA behavior, would fall under Code 8. Once again, if two different levels of support are used, code the most typical level of support needed, and write in any qualifying comments in the behavior box.

Code 7 is to be used only if the person can never be left alone in a room and must always be in constant line of sight for behavioral support during waking hours. Constant line of sight indicates the person must always be within a support person's vision.

For Code 8 to be used, the person can never be left alone in a room, and must always need to be within arm's length during waking hours for behavioral support. Arm's length support indicates a support person is clearly assigned to that one person as his/her sole responsibility for the duration of his/her assignment. During this time period, the support person must always be within arm's length of that person to provide instant support if needed for the particular behavior. For Code 8 to be used, one staff member would be supporting only one person at any one time.

> *John has a history of PICA behavior. He John has not had a PICA episode as a result of an effective treatment plan. This fact results in a Support Required code of 1, monitor only using a person and a treatment plan. Support Level for this item would be coded an 8, as his treatment plan specifies that he never be left alone and always be within arm's length, to assure that John does not engage in PICA.*
>
> *Cheryl has a history of aggressive behavior. If Cheryl does escalate and becomes aggressive, it often requires one person to physically manage and re-direct her. In this case the Support Required is 3. Since her behavior support plan has been successfully introduced, Cheryl has become aggressive only three times in the past 12 months. As a result, her Support Level would be coded a 1, less than monthly.*

Questions 39 - 49

Behaviors in past year includes specific behaviors requiring monitoring or a treatment plan which have happened in the past year. *Behaviors exhibited over 12 months ago should only be considered in this first section if a treatment plan is still in actively in place to manage them.* The two exceptions to this are questions 50 and 51, which refer only to sexually inappropriate behavior or criminal concerns happening in the past year. Sexual and criminal issues from more than one year ago are covered in questions 52 - 55. Descriptions or examples of each behavior are provided in the form.

Questions 52 - 55

History of sexual or physical assault or criminal behaviors (more than one year ago) refers to specific, serious behaviors which occurred more than one year ago. To be included in this section, the person must have shown this behavior more than one year ago. When determining type and level of support, consider waking hours only. Descriptions or examples of each behavior are provided in the form.

Question 512refers only to aggressive sexual behaviors, and does not include non-aggressive sexually inappropriate behavior. Sexual aggression only includes those sexual behaviors which are acted out against or upon someone else as an act of sexual aggression or sexual assault. In addition, it must have happened more than one year ago, or else it would be included in the above current behavior section.

Question 55 ust only be marked "yes" if the person is on the official sex registry for the State of Connecticut.

Questions 56 – 57 a, b

Diagnosed psychotic disorder (question 56) or mood disorder (question 57a) condition only include those psychiatric or mood disorders which have been formally diagnosed by a doctor, psychiatrist, or psychologist. The condition can be diagnosed at any time in a person's life to be included, as long as a treatment plan is still actively in place to manage the condition. For those conditions checked yes, fill in the specific diagnosis found and the support typically required due to the mental illness or emotional condition. Next, fill in current status of the condition to indicate whether the condition is well controlled or stable; intermittent or episodic; or uncontrolled or currently in crisis. When determining type of support, consider waking hours only. Use the same process to determine Support Required and Current Status as was done in the Behavior Section. Question 57b. is available to include a third Psychiatric or Mental Health diagnosis if applicable.

Question 58

Question 58 refers only to a greater level of support needed due to behavioral concerns when out in the community. However, this does not include when at his/her day or vocational program or at his/her employment. For example, because of the number of staff available and type of individuals who share a home with the person, in line of sight may be appropriate when in the home. In the community, however, the person may need to be within arm's length to prevent bolting.

Safety

Read each question and all examples given before checking either yes or no for each one. Examples are often given to better explain the question, but do not represent all the conditions or situations covered by any one statement. For any answers in this section which are not clear, the evaluator should use his/her professional judgment to mark the response which best describes what is typical for the person, and include any qualifying information in the safety comments box. In this section it may also be necessary to consider the person's overall skills and ability if the opportunity to assess how the person may react has not occurred to make a decision. Selective questions are further described below:

59. This question refers to the most basic self-preservation skill and understanding. A "No" response to this question means that the person because of either physical and/or cognitive limitations would not or could not physically leave the home if threatened by a fire. If the opportunity to test this has not occurred, consider whether the person could be taught the escape route or to respond to the existence of a fire. For individuals who require verbal prompting to leave the home during a fire drill, consider whether they would in fact leave without the prompt if a real fire were to occur. Again, this question seeks to identify those individuals who truly could not react to fire or would not get anyone to help if hurt. This does not seek to answer whether the person would get help if someone else may need medical intervention.

61. It does not matter how or by what means the person gets emergency help, as long as he/she can do so.
65. If the person is not able to make <u>any</u> choices at home (safe or otherwise), mark the question no.
66. If the person is not able to make <u>any</u> choices when not at home (safe or otherwise), mark the question no.
68. Body of water includes any body of water outside the home or residence, such as a swimming pool, pond, lake, river, or ocean.
69. If the person is continually purchasing over the phone or internet multiple items he/she does not need, this also indicates the person cannot avoid being taken advantage of financially.
74. At risk because of refusal of critical services includes refusal by the person him/herself or refusal by his/her parent or other support person, if this refusal puts the person at risk of harm or injury. For example, a parent refusing to take their adult child to the doctors, even when the person is sick. The person him/herself could also refuse assistance from a support person which then puts his/herself at risk. For example, the person refusing assistance from a support person to work together to make sure that his/her prescriptions are filled in a timely manner, to pay his/her bills on time, or to maintain a safe home environment.

<u>Question 77</u>

For question 77, check each box for any incidences that the person experienced in the <u>past 12 months</u>. If the person has experienced none of these incidences, check the last box only: None of the above.

Waking Hours Level of Support

Support includes any type of assistance, monitoring, or supervision. This can include medical care, supervision, or any other type of assistance required by the person. This does not include non-required support or support given for any other reason. For example, a RH may be continuously staffed, providing "continuous" support for all the residents there. However, there may be residents who do not need continuous support or monitoring, and who could be safely supported with periodic monitoring or checking in once a day. For a person like this, the LON should reflect what the person truly needs (once a day support), not what is provided at his/her residence (continuous support).

For waking hours of support, consider the support needs of the person for support, monitoring or assistance during waking hours only (overnight support is assessed later in the form). ***For this section, only consider what support the person truly needs, not what is currently provided to them.*** As with the Health and the Behavior sections, waking hours level of support is assessed separately for support needed when at his/her day, school, employment, or vocation program versus when at his/her home or residence. For individuals without services, indicate the predicted level of support, and for school aged children, only use the options under Support Required the Entire Time as the child is always supervised at the school setting.

Question 79

If no support is required during day, school, vocational, or employment, check the box for No support required, and go to question 78. If periodic, or not continuous, support is required for these activities, check the one box under Periodic Support Required which best describes the person's support required in this category, and go to question 78. If continuous support is needed for these activities, check the one answer under Support Required for the Entire Time which best reflects the person's support needs, and go to question 78. For people without employment, day, or vocational services, indicate what support the person would need in order to participate in these activities, or the predicted level of support for these activities.

For individuals who receive the day service in the home setting, question 77 must still be completed.

Question 81

For question 81, check the one answer that best describes how often the person needs support, monitoring, or assistance during waking hours while at his/her home or residence.
Once again, the frequency of support or assistance typically needed by the person, not just currently given, should be recorded. If the frequency needed falls between two levels, choose the level that is most typical of the assistance needed by the person. Different types of support can be added here, *unless the assistance is given at the same time*. For example, consider a person living in an apartment who needs someone to physically check in on him/her once a day, and twice a week needs someone to refill his/her pill box. As the person checking in on him/her will also refill the pillbox, the frequency of support would be once a day, as it i*s given at the same time*.

Question 82

For question 82, check the one answer that best describes the level of support the person needs during waking hours while at his/her home or residence. Periodic in-person support refers to someone physically going to see or assist the person, and may include additional on-

call support. Greater levels of support can be provided in either a large or small group setting, or as one to one. One to one support only, either at arm's length or in constant line of sight should only be checked if the person can never be left alone in a room, not even for a brief time.

Question 83

For question 83, consider first if the person could be safely left alone in his/her residence or home with no other adults at home. If the person cannot be safety left alone at home with no other adults in the residence, indicate 0 hours. If the person can be left alone in his/her residence with no other adults at home, indicate the total number of hours at one time it would be safe to do so.

Overnight Support, Monitoring or Assistance

Question 84

Assistance for support includes any type of assistance, monitoring, or supervision. Consider the support needs of the person for support, monitoring or assistance during sleeping or overnight hours only. ***As with waking hours of support, when answering question 84 consider what overnight support the person truly needs – this may or may not be the same as what is currently provided to him/her.*** Overnight support does not require that someone physically do something in support of the person; it also includes the basic level of supervision or presence of another person that may be needed during the overnight hours.

Consider issues such as: Is the overnight awake staff person there for this person or for one of his/her housemates? Does this person need just on-call overnight support, or a person in the residence who can be sleeping? Check only one answer to represent the amount of support typically needed during overnight hours. For the last answer to be checked, the person must require not only for a person to be awake throughout the night, but also for him/her to be either in constant line of sight or at arm's length of a support person through the overnight hours.

Comprehension and Understanding

The descriptions given in parentheses for questions 86 – 88 are given as examples to help guide the evaluator in choosing the correct answer. These examples are not the only way to assess a person's comprehension and understanding, and may or may not be applicable to the person. The service coordinator evaluator should use his/her best professional judgment to choose the most applicable response for the person. Any additional comprehension comments may be included in the comprehension and communication comments box.

Question 86

Simple instructions or questions ask the person only about one activity at one time, and usually consist of only one subject and one verb without any additional phrasing.

Question 85

Complex instructions or questions usually consist of two or more parts to the sentence. Complex questions may ask the person about two different activities in the same sentence. Complex questions may also include qualifying phrases (for example, When you go to the store today, remember to pick up the milk and bread that you need).

Communication

Please check the one description which best describes the person's ability to communicate, both expressively (sending words or messages) and receptively (receiving words and messages). Descriptions are provided for each answer choice to help guide the evaluator in choosing the response which best describes the person's ability to communicate. Any additional communication comments may be included in the comprehension and communication comments box. This question does not evaluate the person's comprehension abilities, which is covered in questions 86 – 88.

Question 89

This question is not meant to evaluate whether the person communicates in a verbal language other than English – that is assessed in question 91. For question 89, mark answer choice number one if the person uses verbal language with little or no difficulty, both expressing (sending) and receiving language. The second choice includes at least some verbal communication. The third answer choice includes a variety of ways to communicate nonverbally, including sign language, written words, communication boards, pictures, or electronic systems. The fourth answer choice includes those people with severe communication difficulties who do not use alternative communication devices. A person with these communication abilities uses little or no expressive communication, but may use some non-verbal communication skills such as pointing, eye gazing, or facial expressions. The last answer choice is for those people who are unable to communicate.

Question 90

This question focuses on the person's ability to engage in typically understood rules of conversation .

Question 91

This question assess the person's ability to speak English. If the person is nonverbal or uses a sign language, choose the third answer choice (Not applicable – person uses alternative communication system or cannot communicate).

Transportation

Questions 92 - 96 consider how the person gets to places out of walking distance, some issues which may complicate the person's transportation, and the person's ability to arrange or schedule his/her own transportation. Any additional issues concerning transportation which affect a person's level of funding may be included in the transportation and social/community activities box at the end of the next section. Please note that questions 94 and 95 require further explanation if "Yes" is chosen.

Question 92

First read all the answer choices, then check all the ways the person usually gets to places out of walking distance.

Question 95

Question 95 asks if the person always requires someone else in addition to the driver to be in the vehicle with him/her for behavior or health reasons. That is, someone other than the driver would need to ride with the person whenever the person is in a vehicle. If "Yes" is checked, please provide an explanation in the comments box at the end of the form.

Social Life, Recreation, and Community Activities

It is important that the items in this section are answered without thinking about the transportation or mobility assistance which may or may not be needed to do the activity. Support for transportation and mobility is assessed in previous sections, and should not be considered when answering this section. This section focuses instead on any other personal assistance which supports the person in participating in his/her friendships, recreation, and social activities. As with other questions in this form, the evaluator or service coordinator must use his/her best professional judgment when answering these questions. Any additional comments may be included in the transportation and social/community activities comments box.

Questions 97 - 102

Any person's ability to make friends and supportive relationships may be influenced by their abilities in other areas, such as his/her ability to communicate, any serious health conditions, or any behavioral concerns. Who a person considers his/her friend or supportive relationship will vary from person to person, and may include members of his/her family, non-related friends, co-workers, support staff, or others.

Likewise, each person's leisure activities or hobbies done at his/her residence will vary depending on the person's interests as well as other issues such as his/her ability to communicate, any serious health conditions, or any behavioral concerns. Leisure activities is also broadly defined, and may include personal hobbies or other interests such as TV, music, reading, puzzles, or other activities.

Question 99

As with questions 97 and 98, any transportation or support need for transportation only should not be considered when answering this question. Community activities is also broadly defined, and may include movies, church, bowling, Special Olympics, dances, or other activities done in the community. However, community activities does not include taking rides without an intended destination in the community.

Person's Own Parental Responsibilities

This section concerns any children or parental responsibilities the person has themselves. If the person has no children, mark question 103 "No," leave question 104 blank, and skip to question 106.

Primary Caregiver Support

Primary caregivers provide unpaid, direct care for the person and are usually responsible for the person's care. Other unpaid support the person may have is considered in question 111, and should not be included in questions 106 – 110. Any additional comments may be included in the unpaid caregiving comments box.

Question 106

To be considered as his/her own primary caregiver, a person must live independently in the community, with no or only minimal monitoring, and must not have a primary caregiver other than themselves. A person who lives in a residential setting, or who has extensive paid support, would not be considered his/her own primary caregiver. If the person is his/her own primary caregiver, mark question 106 "Yes," leave questions 107 - 110 blank, and skip to question111, Other Unpaid Supports.

Questions 107 - 110

Primary caregivers provide unpaid, direct care for the person and are usually responsible for the person's care. A primary caregiver is typically a parent, close relative, or Host Home provider with whom the person lives, or spouse/partner only if that person provides regular unpaid direct care. Otherwise spouse might be an appropriate category in question111. Primary caregivers do not include RH/group home or other support people who are paid.

People are considered to not have a primary caregiver if he/she does not receive unpaid, direct care from a family member or Host Home provider responsible for his/her care. If the person lives in his/her own home without family members and does not receive daily regular support from family members, please document that support in question 111 as Other Unpaid Supports. This section is intended to capture the circumstances of primary caregivers who are relied upon for very regular/daily support. If the person does not have a primary caregiver, answer question 107 "No," leave questions 108 – 110 blank, and skip to question 111, Other Unpaid Supports.

In addition to a primary caregiver, a person may also have secondary, unpaid, caregiver. This is the case when both parents provide unpaid care to their child with intellectual challenges, or when a HOST HOME primary provider's spouse or partner also provides unpaid support. For the purposes of this form, one parent is then designated the primary caregiver, and the other the secondary caregiver. To be considered as a secondary caregiver, the caregiver must also provide unpaid, direct care for the person and be responsible for the person's care. For the purposes of this form, only one person may be considered as a secondary caregiver, and a person may not have a secondary caregiver if he/she does not have a primary caregiver.

Question 110

Check the box in the first column if any of the following apply to the primary unpaid caregiver. Information may be obtained from the caregiver, other team or support staff members, or the person's record. Check any in the second column that apply to the secondary unpaid caregiver

(such as when two caregiving parents). If no secondary caregiver, leave the second column blank. Do not include any paid caregiving support. Check all that apply.

Other Unpaid Support

Other unpaid support and assistance may also be provided to the person by his/her family or wider network of friends and relationships. Examples of unpaid support or assistance provided by the person's wider network of relationships include a neighbor providing a ride, a co-worker providing guidance at work, or a roommate making sure the person's bills get paid on time.

Question 111

This question asks the team to check all people in the person's life that provide him/her with regular unpaid support or assistance at least one a month. If a category for a support person is missing, write it in the blank space provided. Any additional comments may be included in the unpaid caregiving comments box.

Any Other Concerns

Question 112

Include here any other concerns or considerations not captured elsewhere on this tool which may impact this person's need for support.

Information About Person(s) Filling Out This Form

Once the form is complete, clearly print for all members of the team who assisted in filling out the form:

- The full name of each team member, beginning with the case manger,
- His/her relationship to the person,
- His/her work or daytime telephone numbers, and
- The date the form was completed.

This project sponsored by the Independence Plus in Home and Community-Based Services Grant (#11-P-92079/1-01) funded by the Centers for Medicare and Medicaid Services and the Connecticut Department of Developmental Services.

	Level of Need (LON) Application	Effective Date: November 7th, 2011

Developmental Disabilities Administration

1.0 Accessing the LON Application

Website: http://mrdda.dc.gov/lon/login.aspx

To login to the application:
Please use your current MCIS ID and Password to access the system. By default, you will have access to the same individuals that appear in MCIS.

Important Note:
The application will end the session once the 2 hour timer expires. To avoid any potential loss of data, please save in regular intervals.

2.0 Using the LON Application

1. To begin using the tool, select a client just as you would in MCIS.
2. Once the client loads, any assessments that have been started or completed will be displayed.
3. Staff can create/update/view assessments by selecting the following:

    a. New - Selecting this button will allow you to create an assessment.
    b. Edit - Selecting this button will open the assessment and allow you to make changes to be saved.
    c. View - Selecting this button will open the assessment in read only mode. Changes/updates will not be allowed.
    d. Once a assessment is open for edit, staff can complete the following:
        i. Save | Cancel | Commit
            1. Save – This will save any progress
            2. Cancel – This will close the assessment without saving changes
            3. Commit – This will mark the assessment as completed

4. Staff can view summary reports by selecting the following:

    a. Report - Selecting this button will display the assessment summary report. This can only be run for assessments that have a status of completed.
    b. Risk Analysis Report - Selecting this button will display the risk analysis based on the assessment. This can only be run for assessments that have a status of completed.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Effective Date: November 14, 2011	Number of Attachments: 6
Responsible Office: DDS Deputy Director, Developmental Disabilities Administration	
Supersedes Policy: N/A	
Title/Subject: **DDA Level of Need Assessment and Screening Tool**	
Cross-References: Individual Service Plan Policy and Procedure; HCBS Waiver Application Process; Level of Care Determination Policy	

All underlined words/definitions can be found in the **Definitions Appendix**.

1. PURPOSE

The purpose of this policy is to introduce the use of a comprehensive and uniform assessment tool designed to provide an assessment of a person's support needs for the person-centered planning process, to identify potential risks to be addressed by the person and his/her planning team, and to provide uniform information upon which the District will make Level of Care determination decisions for eligibility for participation in the ICF/IDD and ID/DD Home and Community-Based Services Waiver programs.

2. APPLICABILITY

This policy applies to all DDA employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of individuals with disabilities receiving services as part of the DDA Service Delivery System funded by DDA or the Department of Health Care Finance (DHCF).

3. AUTHORITY

The authority for this policy is established in the Department on Disability Services as set forth in D.C. Law 16-264, the "Department on Disability Services Establishment Act of 2006," effective March 14, 2007 (D.C. Official Code § 7-761.01 *et seq.*); and D.C. Law 2-137, the "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978," effective March 3, 1979 (D.C. Official Code § 7-1301.01 *et seq.*).

4. POLICY

It is the policy of DDS that every person served by DDS has a comprehensive assessment of support needs and risk screening completed upon admission to services and at least annually thereafter as part of the annual Individual Service Planning process, and for level of care determination decisions for participation in the ICF/ID and ID/DD Home and Community-Based Services Waiver programs. DDS has adopted the DC DDA Level of Need Assessment and Screening Tool ("DC DDA LON"), with permission from the State of Connecticut and the Centers of Medicare and Medicaid Services, to complete the assessment evaluation and risk screening process.

5. RESPONSIBILITY

The responsibility for this policy is vested in the Director, Department on Disability Services. Implementation for this policy is the responsibility of the Deputy Director, Developmental Disabilities Administration.

6. STANDARDS

The following are the standards by which DDS will evaluate compliance with this policy:

A. The DDA Intake Service Coordinator will complete the DC DDA LON for all individuals who have been found eligible for services. The assessment will be completed based on: interviews with the individual, the authorized representative, family members, guardians, friends, school teachers, and/or other service providers; review of the medical, dental and psychological evaluations; and, review of other available history as found in educational records, other service records, social work assessments, and related medical records as may be available at the time of the intake process.

B. The completed assessment and LON Report will be provided to the person and is maintained in the DDA electronic case record system.

C. The completed LON assessment will be reviewed by the person's support team at the time of the Initial Individual Support Plan meetings and be updated as needed at that time.

D. The LON assessment and Report must be provided by DDA as part of any referral of a person to an ICF/IDD program for the ICF/IDD provider's use in the admission decision.

E. The LON assessment and Report must be submitted to DHCF as part of the Level of Care determination package for admission to an ICF/IDD program, and the LON Report must be submitted at part of each annual re-determination review.

F. The LON Report must accompany any eligibility application completed by a DDA Service Coordinator on behalf of an individual for the DDA HCBS waiver program for use in the Level of Care determination.

G. The LON assessment must be updated on at least an annual basis as part of the annual ISP review and Level of Care re-determination processes by the individual's support team for persons enrolled in the DD/IDD HCBS waiver program.

H. The DDA Service Coordinator is responsible to ensure the LON assessment and Report are updated on at least an annual basis, or, whenever there is a significant change in a person's support needs as part of a case review and/or amendment to the ISP if needed.

I. The person's entire team (e.g. the person, authorized representative, family members, friends, advocates, court-appointed attorney, guardian, Residential QMRP/Program Specialist, Day/Vocational Program Specialist, Nurse, and/or consulting clinicians) is expected to jointly review the LON assessment during the pre-ISP meeting, ISP meeting and/or case conference as applicable to ensure that all team members agree with the responses. Only the DDA Service Coordinator has the authority to commit the completed assessment to the record and subsequently generate the LON Report findings.

J. Support team members may only access the on-line LON assessment data system by requesting an MCIS username and password through the DDS Information

Technology Unit. The Provider must identify the specific individuals served by DDA for whom each team member is an authorized participant.

K. The LON assessment must be maintained in the assessment section of the person's Provider record.

L. The LON Report must be maintained in the ISP section of the person's Provider record.

Laura L. Nuss, Director

11/14/2011
Approval Date

Attachments:

1. Level of Need Assessment and Risk Screening Tool Procedure
2. DC DDA LON Assessment and Risk Screening Tool version 1.1
3. LON Summary Report example
4. DC DDA LON Guide version 1.1
5. DC DDA LON Website Instructions
6. Request for MCIS access Form

DC DMR Level of Need Assessment and Screening Tool

Date: _____ Type: _____ HCBS Waiver: ____ ICF/IDD: ____

_____ ____ _____ _____

First name MI Last name Date of birth

The answers on this form should reflect how much support or assistance the person needs or requires, *either for the management of a behavioral or health condition or to complete a task or activity. This may not be the same as how much support or assistance the person is currently receiving. Unless specifically asked to do otherwise, consider the past 3 to 6 months when answering the questions.* ***Please check only <u>one</u> box per item,*** *unless specifically asked to do otherwise. Include any explanations in the comments boxes.*

Health and Medical

Please check Yes for any prescribed medical treatments; check No if this treatment is not prescribed. Then insert codes for how often the treatment (or care for the treatment) is required, and who typically provides this care or support. Descriptions are given to better determine support frequency.

Support Frequency – How often care or assistance is typically needed for each treatment:

1 = Less than once a week
2 = Once a week
3 = Several times a week
4 = Once a day
5 = Multiple times a day
6 = Continuous

Support Provider – Who typically provides this support:

1 = RN
2 = LPN
3 = Respiratory therapist
4 = Physical therapist
5 = Occupational Therapist
6 = Unlicensed direct care staff
7 = Family member or friend
8 = Self

	At Home or Residence				At Day, School, Job, or Vocational Program			
Prescribed treatment or care	**Yes**	**No**	**Support Frequency**	**Support Provider**	**Yes**	**No**	**Support Frequency**	**Support Provider**
1. Catheter – If catheter is used continuously, consider catheter care only, such as insertion, removal, cleaning catheter, emptying bag.	☐	☐	____	____	☐	☐	____	____
2. Needle injection – Consider how often an injection is given.	☐	☐	____	____	☐	☐	____	____
3. Inhalation therapy or nebulizer – Consider how often each treatment is needed. This does not include oxygen.	☐	☐	____	____	☐	☐	____	____
4. Oxygen – If the oxygen is used continuously, consider how often care is needed to administer the oxygen; otherwise, consider how often oxygen is needed.	☐	☐	____	____	☐	☐	____	____
5. Respiratory suctioning – Consider how often respiratory suctioning is needed.	☐	☐	____	____	☐	☐	____	____
6. Wound Care – Consider how often wound care is needed.	☐	☐	____	____	☐	☐	____	____
7. Ostomy (colostomy or ileostomy) – Consider care related to the ostomy, such as cleaning the tube area or emptying the bag.	☐	☐	____	____	☐	☐	____	____
8. Tracheostomy – Consider care of stoma, cannula, and any other trach care.	☐	☐	____	____	☐	☐	____	____
9. Tube feeding (nasogastric, G, or J tube) – Consider how often tube feeding required.	☐	☐	____	____	☐	☐	____	____
10. Artificial ventilator – This refers to mechanical ventilators which breathe for the person and are on continuously. Consider care and monitoring of ventilator.	☐	☐	____	____	☐	☐	____	____

11. If the family member as primary provider is not available for any of the above treatments, is this care then provided by a medically licensed support provider (for example, by an RN, LPN, respiratory therapist or physical therapist)?
- ☐ No
- ☐ Yes
- ☐ Not applicable – Above care not provided by a family member or not needed

12. Does the person require any **hands on or direct care from a nurse** (LPN or RN) to provide routine care? This does not include routine examinations or assessments, such as blood pressure checks, incident monitoring, monthly assessments, etc.
- ☐ No → **If No, Skip to Question 14**
- ☐ Yes

13a. How often is this hands on or direct care from a nurse (RN or LPN) currently needed?
- ☐ 1 – 5 times a year
- ☐ 6 – 11 times a year
- ☐ Once a month
- ☐ 2 – 3 times a month
- ☐ Once a week
- ☐ 2 – 3 times a week
- ☐ 4 – 6 times a week
- ☐ At least once a day

13b. If daily hands on or direct care from an LPN/RN is needed, how much LPN/RN care is needed?
- ☐ Direct nursing care is not needed every day
- ☐ Less than 8 hours a day
- ☐ 8 to less than 16 hours a day
- ☐ 16 to less than 24 hours a day
- ☐ Continuous, 24 hour direct nursing care required
  If continuous nursing care needed, provide explanation in box at end of health section.

14. **In the past year**, how often did the person have a grand mal or convulsive seizure? Note: Other types of seizure activity are asked about in question 15.
- ☐ None in past year
- ☐ Less than once a month
- ☐ Once a month
- ☐ Several times a month or weekly
- ☐ Several times a week or more
- ☐ N/A – Has never had a seizure

15. **Check all the developmental disability diagnoses that apply:**
- ☐ Intellectual Disability
- ☐ Cerebral palsy
- ☐ Down Syndrome
- ☐ Prader Willi
- ☐ Other chromosomal disorder (Fragile X, Klinefelter's Syndrome, etc.)
- ☐ Autism, Asperger's Syndrome, or pervasive developmental disorder
- ☐ Brain injury (TBI, ABI)
- ☐ Spina bifida
- ☐ Fetal alcohol syndrome
- ☐ Other neurological impairment (includes meningitis, hydrocephalus, etc.)
- ☐ Other: _____

16. **Check all diagnosed health conditions:**
- ☐ No diagnosed health conditions
- ☐ Allergy – not life threatening
- ☐ Allergy – severe or life threatening
- ☐ Arthritis (osteoarthritis or rheumatoid arthritis)
- ☐ Asthma
- ☐ Auto immune disorder (rheumatoid arthritis, multiple sclerosis, lupus, etc.)
- ☐ Blindness – no functional eyesight
- ☐ Cancer
- ☐ Chronic constipation or diarrhea
- ☐ Deafness – no functional hearing
- ☐ Dementia or Alzheimer's disease
- ☐ Dental or gum disease
- ☐ Diabetes – oral medication required
- ☐ Diabetes – injected medication required
- ☐ Dysphagia (swallowing disorder)
- ☐ Eating disorder (anorexia or bulimia)
- ☐ Epilepsy or seizure disorder
- ☐ Foot or nail condition requiring podiatrist care
- ☐ GERD, acid reflux, or reflux esophagitis
- ☐ Heart condition
- ☐ Hepatitis
- ☐ High blood pressure or hypertension
- ☐ High cholesterol, hypercholesterolemia, or hyperlipidemia
- ☐ Kidney disease requiring dialysis
- ☐ Osteoporosis or osteopenia
- ☐ Parkinson's disease
- ☐ Pregnancy
- ☐ Pressure ulcer
- ☐ Pulmonary condition (emphysema, COPD, pulmonary edema)
- ☐ Severe scoliosis
- ☐ Sleep apnea
- ☐ Stroke or CVA
- ☐ Substance abuse – current
- ☐ Substance abuse – history of
- ☐ Hyperthyroid, hypothyroid, or thyroid disease
- ☐ Over weight
- ☐ Under weight
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

17. **Check all of the following which currently apply:**

- ☐ Requires food or liquid to be in particular consistency or size (for ex., chopped into specific pieces, ground up, pureed, thickened, etc.). Describe: _____
- ☐ Food consistency requirement change within past 3 months. Describe: _____
- ☐ Medically prescribed special diet (for ex., diabetic, low salt, high/low calorie, etc.). Describe: _____
- ☐ Unusual food preferences or food aversion. Describe: _____
- ☐ History or risk of dehydration
- ☐ History or risk of choking (swallowing risk factors include coughing during or after meals, excessive throat clearing during or after meals, or gagging on food or liquids)
- ☐ Currently smokes
- ☐ Two or more falls within past 3 months
- ☐ Hands on assistance or close supervision required to use stairs within his/her residence
- ☐ Tactile kinesthetic issues (for example, hypersensitivity to touch and other sensory stimulation such as light or sound)
- ☐ Medical devices (for ex., pacemaker, C-PAP machine, glucometer, seizure management device, prosthetic device, etc. Does not include glasses, contacts, or hearing aids). Describe: _____
- ☐ None of these apply

18. **Medical office visits, or off-site medical or mental health care**

Typical number of office visits person had in past year to see a licensed professional for medical or mental health care (such as a doctor; dentist; nurse; laboratory technician; physical, respiratory, or speech therapist; podiatrist; psychiatrist; psychologist; or behavioral therapist). This does not include in-home visits. Consider off-site medical or mental health office visits only (includes emergency room visits).

- ☐ None in past year
- ☐ 1 – 5 times a year
- ☐ 6 – 11 times a year
- ☐ 12 – 23 times a year
- ☐ 2 – 3 times a month
- ☐ Once a week
- ☐ 2 or more times a week

19. Please describe any problems with off-site medical appointments (for example, problems with getting to office):

_____

_____

20. **If person is currently hospitalized (medical or psychiatric) or in a rehabilitation facility:**
    a. Is a written discharge plan in place?
        - ☐ Yes
        - ☐ No
        - ☐ Person is not in a hospital/rehab facility
    b. Anticipated date of discharge: _____

21. **Please check all that apply regarding medications:**

- ☐ Medication/s require careful monitoring for side effects
- ☐ Heart medications or blood thinners (Lasix, Digoxin, Coumadin, etc.)
- ☐ Anti-seizure medications (Depokote, Dilantin, Valproic Acid, Phenobarbital, etc.)
- ☐ Concurrent use of two or more over-the-counter medications
- ☐ Frequent changes in medication
- ☐ Prescribed addictive medication (Codeine, Percocet, Vicodin, chloralhydrate, Oxycontin, etc.)
- ☐ Long-term use of a neuroleptic, psychotropic, mood or behavioral medication (Haldol, Klonopin, Ativan, Lithium, etc.)
- ☐ Frequently refuses to take prescribed medications
- ☐ Other medication risk (self-administration error, allergy to medication, etc.) – describe: _____
- ☐ None of these apply, or does not take any medications

Comments about health and medical:

Personal Care Activities

Please check the **one** box which best describes how much support the person **typically** requires to do each activity:

22. Dressing and undressing – includes ability to take clothes out of drawers, choose weather appropriate clothes, and use fasteners.
    - ☐ Dresses self independently. May use assistive devices, such as a reacher/extender, etc.
    - ☐ Able to get dressed, but needs prompting, or may need help with choosing weather appropriate clothing.
    - ☐ Requires hands on assistance with getting dressed.

23. Bathing or showering – includes sponge bath, tub bath or shower.
    - ☐ Draws bath and washes self independently, may use assistive devices, such as grab bars, bath brush, etc.
    - ☐ Able to bathe self, but may need help regulating water temperature or some type of prompting, monitoring, or encouragement. May need help washing back.
    - ☐ Requires hands on assistance to wash self and/or to get in and out of tub or shower.

24. Grooming and personal care – includes brushing teeth or hair, or shaving (electric or regular razor).
    - ☐ Grooms self and independently does own personal care. May use assistive devices.
    - ☐ Brushes teeth, shaves, and brushes hair, but needs some prompting or encouragement.
    - ☐ Requires hands on assistance to complete grooming activities.

25. Using the toilet – includes going to the bathroom for bowel and urine elimination, wiping self, menstruation care, diaper care, and ostomy/catheter care.
    - ☐ Uses toilet independently, may use assistive devices such as a raised toilet seat, etc.
    - ☐ Uses the toilet and wipes self with reminders, prompting, or encouragement.
    - ☐ Requires hands on assistance for toileting needs. May be incontinent. Includes those individuals using diapers, catheter, or ostomy.

26. Eating – includes ability to use fork or spoon from plate to mouth and to cut food. Does not include chewing or swallowing (covered in next question).
    - ☐ Eats independently. May use assistive devices.
    - ☐ Eats with reminders, prompting, or encouragement. May need assistance with cutting up food or prompting for pace.
    - ☐ Requires hands on assistance with putting food on utensil or requires hand over hand feeding.
    - ☐ Requires assistance for NG, G, or J tube feeding.

27. Chewing and swallowing – includes ability to chew food and swallow food without choking.
    - ☐ Chews and swallows independently.
    - ☐ Chews or swallows with monitoring, supervision, prompting or encouragement.
    - ☐ Cannot chew or swallow food or liquid.

28. Mobility in the home – includes the ability to move around inside the home or residence. How does this person usually get around inside the home?
    - ☐ Walks by self with or without assistive devices, such as a brace, walker, cane, prosthesis, etc.
    - ☐ Walks by self, but may require physical support or assistance from another person.
    - ☐ Does not walk. Uses wheelchair or scooter independently to get around.
    - ☐ Does not walk. Uses wheelchair with assistance from another person (such as to push wheelchair).

29. Transferring – includes ability to move from bed to a chair or to a wheelchair.
    - ☐ Moves in and out of bed or chair independently. May use assistive devices.
    - ☐ Moves in and out of bed or chair with monitoring, prompting, or encouragement.
    - ☐ Requires hands on assistance to transfer.

30. Changing position in bed or chair – includes ability to turn side to side. Does *not* include ability to get up out of bed or chair.
    - ☐ Changes position in bed/chair independently. May use assistive devices.
    - ☐ Changes position in bed/chair with some prompting or encouragement.
    - ☐ Requires hands on assistance to change position in bed/chair.

Comments about personal care activities:

Daily Living Activities

Please check the **one** box which best describes how much support the person **typically** requires to do each activity. Use best professional judgment and consult with others who know the person well if any uncertainty or if lack of opportunity to demonstrate. Write any comments in box following this section.

31. Mobility in the community – includes the ability to move around outside and in the community. *Does not include any transportation needs.*
    - ☐ Walks by self with or without assistive devices, such as a brace, walker, cane, prosthesis, etc.
    - ☐ Walks by self, but may require physical support or assistance from another person.
    - ☐ Does not walk. Uses wheelchair or scooter independently to get around.
    - ☐ Does not walk. Uses wheelchair with assistance from another person (such as to push wheelchair).

32. Taking medications – includes taking the correct medication and dose at the correct time or filling pillbox if used. Includes monitoring glucose level if needed.
    - ☐ Takes medications correctly by self (correct medication, correct dose, correct time). May use assistive devices such as a pillbox, etc.
    - ☐ Takes medications with monitoring, prompting, or reminders, or may need assistance to set up a weekly or daily pillbox.
    - ☐ Requires assistance to take medications, such as to prepare or administer the medication.
    - ☐ Does not take medications.

33. Using the telephone – includes dialing the number and/ or communicating over the phone.
    - ☐ Uses the telephone independently. May use assistive devices to dial or communicate over the phone (such as programmed dialing, TTY, etc.).
    - ☐ Uses telephone with prompting, instruction, or encouragement. May need assistance with dialing numbers.
    - ☐ Always requires assistance to use telephone or TTY, or cannot use telephone at all.

34. Doing household chores – includes housecleaning, laundry, etc.
    - ☐ Does household chores by self independently. May use assistive devices.
    - ☐ Does household chores with prompting, monitoring, instruction, or encouragement.
    - ☐ Requires assistance to complete household chores, or cannot complete household chores at all.

35. Shopping and meal planning – includes planning for meals and shopping for groceries or other goods in neighborhood area. *Does not include any transportation required.*
    - ☐ Plans for meals and shops for groceries, etc., in neighborhood stores independently. Excludes any transportation. May use assistive devices.
    - ☐ Plans for meals and shops in neighborhood stores with prompting, monitoring, or instruction. Excludes any transportation.
    - ☐ Requires assistance for meal planning and shopping, such as someone to make the grocery list or pay the cashier; or cannot do any part of shopping and meal planning at all. Excludes any transportation.

36. Meal preparation and cooking – includes getting the food out of the cupboard or refrigerator, preparing food (including making food into appropriate consistency such as ground up, specified piece size, pureed, or liquefied), making cold meals (such as sandwiches or snacks), and cooking simple meals.
    - ☐ Prepares and cooks food independently using either microwave or stove. May use assistive devices. Can make cold foods (sandwiches, snacks) or simple meals.
    - ☐ Prepares and cooks food such as sandwiches and simple meals with prompting, monitoring, or instruction. Can safely use a microwave with instructions, prompting, or monitoring.
    - ☐ Requires assistance to prepare and cook food. Cannot use either microwave or stove.

37. Budgeting and money management – includes being able to budget for expenses within a set income and pay bills.
    - ☐ Budgets, pays bills, and manages own money independently. May use assistive devices.
    - ☐ Budgets, pays bills, and manages money with prompting, monitoring, or instruction.
    - ☐ Requires assistance to budget, pay bills, or manage money, or cannot budget or manage money at all.

38. Transitioning – includes being able to discontinue one activity or task and begin another, including activities at home, school, work, vocational or day program, and leisure or recreational activities.
    - ☐ Transitions from or to activities or tasks by self independently.
    - ☐ Transitions to or from an activity with prompting, monitoring, instruction, or encouragement.
    - ☐ Requires assistance in order to transition from one activity to another.

Comments about daily living activities:

Behavioral and Mental Health

Please check Yes for any behaviors or diagnosed mental health conditions requiring monitoring or a treatment plan in the past year; otherwise, check No. Then fill in the codes for the type of support and level of support typically needed during waking hours for each behavior. Check all that apply. *If type of support required is a 3 or a 4, it is strongly suggested to include a description in behavior comments box on next page.* (Note: Overnight support is assessed in a later section of the form.)

Support Required –
Type of support typically required during waking hours:

0 = No support needed or can ignore behavior.
1 = Monitor only, using a person or through environmental means. Includes monitoring for behaviors controlled by medications or treatment plan.
2 = Verbal or gestural distraction or prompting typically needed.
3 = One person hands-on support typically needed to redirect or manage person.
4 = More than one person (2:1) typically needed to redirect or manage person. If so, please explain in behavior comments box.

Support Level –
Level of support typically needed to manage behavior during waking hours:

0 = No support required
1 = Less than monthly, episodic, or seasonal only
2 = One to 3 times a month
3 = Once a week
4 = Several times a week
5 = Once a day or more
6 = Continuous support during waking hours required for this behavior
7 = Person can never be left alone in a room and must always be in constant line of sight for behavioral support
8 = Person can never be left alone in a room and must always be within arms length for behavioral support

	At Home or Residence				At Day, School, Job, or Vocational Program			
Behaviors in past year	**Yes**	**No**	**Support Type**	**Support Level**	**Yes**	**No**	**Support Type**	**Support Level**
39. Opposes support or assistance Includes resisting care or assistance	☐	☐	____	____	☐	☐	____	____
40. Disruptive behaviors, not aggression Includes any behavior which disrupts or interferes with activities of the person or others.	☐	☐	____	____	☐	☐	____	____
41. Verbal aggression or emotional outbursts Includes verbal threats, name calling, verbal outbursts, and temper tantrums	☐	☐	____	____	☐	☐	____	____
42. Mild physical assault or aggression Does not cause injury, such as pushing, grabbing, or spitting	☐	☐	____	____	☐	☐	____	____
43. Severe physical assault or aggression Can cause injury such as biting, or punching, or attacking	☐	☐	____	____	☐	☐	____	____
44. Property destruction Includes the intentional destruction of property	☐	☐	____	____	☐	☐	____	____
45. Bolting Suddenly running or darting away (excludes wandering away)	☐	☐	____	____	☐	☐	____	____
46. Self-injurious behavior Includes any behavior which harms one's physical self, such as head banging, biting/ hitting self, skin picking, scratching self, etc.	☐	☐	____	____	☐	☐	____	____
47. Eating or drinking nonfood item (Pica) Includes ingestion of items or liquids not meant for food, such as paper clips, coins, detergent, dirt, cleaning solutions, etc.	☐	☐	____	____	☐	☐	____	____
48. Impulsive food or liquid ingestion Includes binge eating or compulsive, rapid ingestion of large quantities of food or edible liquids.	☐	☐	____	____	☐	☐	____	____
49. Wandering away Includes wandering away only	☐	☐	____	____	☐	☐	____	____
50. Sexually inappropriate behavior in past year Includes a wide range of behaviors such as disrobing, sexually inappropriate comments, masturbating in public, as well as sexually aggressive behavior	☐	☐	____	____	☐	☐	____	____
51. Criminal concerns in past year Includes any criminal justice issues or concerns, or problems with the law	☐	☐	____	____	☐	☐	____	____

For questions 52 – 54 please indicate the type of support and level of support required during waking hours using the Support Required and Support Level codes from page 6. Note that questions 52 – 54 ask about the history of certain behaviors or criminal concerns which happened more than one year ago.

History of sexual or physical assault or criminal behaviors (more than 1 year ago)	At Home or Residence: Yes	No	Support Type	Support Level	At Day, School, Job, or Vocational Program: Yes	No	Support Type	Support Level
52. History of sexual assault or sexual aggression towards others	☐	☐	____	____	☐	☐	____	____
53. History of severe physical assault	☐	☐	____	____	☐	☐	____	____
54. History of criminal concerns – Note below if currently on probation or parole	☐	☐	____	____	☐	☐	____	____
55. Is this person on the sex offender registry?	☐	☐						

Psychiatric or mental health condition

For questions 56 and 57, please indicate the type of support required during waking hours for any diagnosed psychiatric or mental health condition using the Support Required codes below. Then indicate the current status of the psychiatric or mental health condition for the past 3 to 6 months using the Current Status scale.

Psychiatric or Mental Health Condition Support Required –
Type of support typically required during waking hours:

0 = No support needed or can ignore behavior.
1 = Monitor only, using a person or through environmental means. Includes monitoring for behaviors controlled by medications or treatment plan.
2 = Verbal or gestural distraction or prompting typically needed.
3 = One person hands-on support typically needed to redirect or manage person.
4 = More than one person (2:1) typically needed to redirect or manage person. If so, please explain in behavior comments box.

Current status (past 3 – 6 months)

1 = Condition is well controlled or stable (includes controlled by medication or other means)
2 = Condition is intermittent or episodic
3 = Condition is uncontrolled or currently in crisis

Psychiatric or mental health condition (include formal diagnosis by mental health clinician)	At Home or Residence: Yes	No	Support Type	Current Status	At Day, School, Job, or Vocational Program: Yes	No	Support Type	Current Status
56. Diagnosed psychotic disorder – Includes schizophrenia, psychosis, schizoaffective disorder, etc. Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____
57a. Diagnosed mood disorder – Includes bipolar disorder, major depression, depressive disorder, etc. Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____
57b. Other diagnosed psychiatric or mental health condition – Write in formal diagnosis: _____	☐	☐	____	____	☐	☐	____	____

58. Does the person require a greater level of support due to behavioral or mental health concerns when out in the community?
☐ No
☐ Yes – *please describe in behavioral, mental, or emotional health comments box*

Comments about behavioral or mental health concerns?

Safety

	Yes	No	
59. The person responds appropriately without prompting to basic safety issues at home – for example, evacuating the residence if there is a fire.	☐	☐	
60. The person responds appropriately without prompting to other safety issues at home – for example, responding appropriately to lack of heat in winter or to a power outage.	☐	☐	
61. The person is able to obtain necessary emergency assistance by some means – for example, dialing 911, pressing an emergency button, getting help from a neighbor, etc.	☐	☐	
62. The person has auditory or visual disabilities that require adaptive or assistive devices necessary for safety (for example, tactile escape route, flashing fire alarm, or bed shaker).	☐	☐	
63. The person requires use of bedrails while sleeping or while in bed.	☐	☐	
64. The person experiences frequent absences or tardiness of his/her support staff or frequently has staff unfamiliar with his/her support needs.	☐	☐	
65. Overall, the person usually makes safe choices when at home – for example, not putting metal in a microwave or toaster, not opening the door to strangers or locking the door at night.	☐	☐	
66. Overall, the person usually makes safe choices when not at home – for example, crossing neighborhood streets safely or refusing a ride from a stranger.	☐	☐	
67. The person responds appropriately to safety issues when not at home – for example, evacuating building appropriately if fire alarm goes off or staying on the sidewalk.	☐	☐	
68. The person is in danger of accessing a body of water without supervision.	☐	☐	
69. The person is able to avoid being taken advantage of financially – for example, not giving his/her money to strangers, or not giving out personal financial or social security information to strangers.	☐	☐	
70. The person is able to avoid being taken advantage of sexually or is able to avoid sexual exploitation, including when at home, in the community, or with strangers.	☐	☐	
71. The person uses the internet, cell phone, or other electronic communication or information devices appropriately. (Check not applicable if person does not have access to these devices.)	☐	☐	Not applicable ☐
72. This person always requires 2 people for transferring, fire evacuation, or positioning.	☐	☐	
73. The person's home is accessible to meet the individual's needs, including bathing facilities.	☐	☐	
74. The person is at risk because of refusal of critical services.	☐	☐	
75. The person is homeless now or is at risk of homelessness.	☐	☐	
76. Are there any other safety concerns in the person's home or neighborhood that could put this person at risk? (**If Yes**, describe in safety comments box below.)	☐	☐	

77. Has the person experienced any of the following incidents in the past 12 months? Please check all that apply:

- ☐ Severe injury
- ☐ Emergency hospitalization
- ☐ Missing persons report
- ☐ Fire requiring emergency response or involving severe injury
- ☐ Victim of assault
- ☐ Victim of rape
- ☐ Substantiated abuse or neglect report
- ☐ Police arrest
- ☐ Vehicle accident with moderate or severe injury
- ☐ Emergency restraint
- ☐ Injury due to restraint
- ☐ Unusual incident or behavior not normally exhibited that was dangerous, illegal, or life threatening
- ☐ Suicide attempt or gesture
- ☐ Other (describe): _____
- ☐ None of the above

Comments about safety:

Waking hours level of support

Consider the support needs of the person for support, monitoring or assistance during waking hours only. (Overnight support is assessed later in the form.)

78. Does the person require any of the following during **waking hours**? This may include waking hours at his/her home or residence, day, school, job, or vocational program, or work. Check all that apply.
    - ☐ Door alarm
    - ☐ Chair alarm
    - ☐ Refrigerator alarm or lock
    - ☐ Other environmental monitoring or alarm (list): _____
    - ☐ None of the above

Day, School, Job, or Vocational Program Level of Support – Waking hours

79. What level of support, monitoring, or assistance is typically needed during employment, day, school, job, or vocational activities only (for those without services, indicate the predicted level of support)? Note: For school aged children, consider only Support Required the Entire Time.

    No support required:
    - ☐ Person is competitively employed or is independent during the day

    Periodic support required:
    - ☐ Job development and training only
    - ☐ Once a week or less
    - ☐ For part of each day or time period spent on employment, day, or vocational activities

    Support required for the entire time:
    - ☐ Larger group support (one staff person for 5 or more people)
    - ☐ Small group support (one staff person for up to 4 people)
    - ☐ One to one support due to personal support needs
    - ☐ More than one person support due to personal support needs

80. On average, how many total hours a week is the person involved in either day, school, job, or vocational program? _____ total hours per week

Home or Residence Level of Support – Waking Hours

81. Frequency of support, monitoring, or assistance – How often does this person typically need support during waking hours at his/her home or residence? Please check only one.
    - ☐ Less than monthly
    - ☐ 1 to 3 times a month
    - ☐ Once a week
    - ☐ Several times a week
    - ☐ Once a day
    - ☐ Multiple times a day
    - ☐ Continuous support needed during waking hours
    - ☐ Person can never be left alone in a room and must always be in constant line of sight
    - ☐ Person can never be left alone in a room and must always be within arms length
    - ☐ No support needed

82. Level of support, monitoring, or assistance – What level of support does this person typically need during waking hours at his/her home or residence? Please check only one.
    - ☐ On-call support only
    - ☐ Periodic in-person support
    - ☐ Lives in family home and needs support always available
    - ☐ Larger group support (one person for 4 or more people)
    - ☐ Small group support (one person for 2 – 3 people)
    - ☐ One to one support only, either at arms length or in constant line of sight
    - ☐ More than one person typically needed
    - ☐ No support is needed

83. During the day, how many hours at one time can this person typically be safely left alone in the house or residence at one time, with no other adults at home? _____ Hours

Overnight support, monitoring, or assistance

84. During overnight/sleep hours, how much support is typically needed for this person? Please check only one.
- ☐ No overnight support is needed
- ☐ Requires on-call support available during the night (someone available by phone)
- ☐ Requires a person in their residence who can be sleeping
- ☐ Requires a person to be awake throughout the night
- ☐ Requires a person to be awake and in either constant line of sight or at arms length throughout the night

85. Does the person require any of the following during overnight or when sleeping? Check all that apply.
- ☐ Bed alarm
- ☐ Refrigerator lock or alarm
- ☐ Other environmental monitoring or alarm (list): _____
- ☐ Door alarm
- ☐ None

Comments about support:

Comprehension and Understanding	**Yes**	**No**	
86. Can the person understand simple instructions or questions (for example, "Did you like your dinner?" or "Raise your arms")?	☐	☐	
87. Can the person understand complex instructions or questions with two different parts (for example, "Do you need eggs from the grocery store?" or "Please put on your coat, and take these letters to the mailbox")?	☐	☐	
88. If the person is age 18 or older, can the person read at the 5th grade level (for example, can the person read the local newspaper)?	☐	☐	☐ Is under age 18

Communication

89. Please check the one description which best describes the person's ability to communicate.
- ☐ Verbal communication with little or no difficulty, both expressing (sending) and receiving language.
- ☐ Verbal communication with some difficulty or limited skills with either expressing or receiving messages.
- ☐ Severely limited verbal (cannot easily form words), or is basically nonverbal. Usually uses alternative method of communicating such as manual or sign language, written words, pictures, electronic systems, communication board, gesturing or pointing, etc.
- ☐ Nonverbal with severe communication difficulties. Little or no expressive communication but may use some non-verbal communication skills such as eye gazing, or facial expressions. Does not use any alternative communication devices.
- ☐ Unable to communicate

90. Does the person follow social rules of conversation appropriately, in different situations and with different listeners? This includes taking turns when speaking, using appropriate language, and using an appropriate tone of voice.
- ☐ Always or most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Never

91. Does the person speak English? Please check one.
- ☐ Yes (or enough that no interpreter is needed)
- ☐ No – person needs a foreign language interpreter
- ☐ No – person needs an interpreter for the deaf
- ☐ Not applicable – person uses alternative communication system or cannot communicate

Comments about comprehension or communication:

Transportation

92. How does the person usually get to places out of walking distance? Check all that apply:
    - ☐ Uses a provider's van or vehicle
    - ☐ Gets ride from staff in staff person's car
    - ☐ Uses public transportation such as city bus
    - ☐ Gets a ride from a family member or friend
    - ☐ Uses para-transit, dial a ride, or Metro Access
    - ☐ Uses taxi service
    - ☐ Drives self
    - ☐ School bus
    - ☐ Other: _____

93. Does the person require a van with a lift?
    - ☐ Yes
    - ☐ No

94. Does the person require vehicle modifications to travel safely? This may include grab bars, seat belt extenders, or wheelchair tie downs.
    - ☐ Yes – please explain: _____
    - ☐ No

95. Does the person require support for his/her behaviors or for health reasons from other person(s) in addition to the driver while in a vehicle?
    - ☐ Yes – please explain: _____
    - ☐ No

96. How much support does this person require to arrange or schedule his/her own transportation? This may include looking up van or bus schedule, calling for ride, canceling ride if not needed, obtaining bus route or driving directions, or taking public transportation. Check only one box.
    - ☐ Able to arrange or schedule own transportation independently. This may include independently arranging for a van ride or using public transportation after initial instruction. Includes people who are able to drive. May use assistive devices, such as a phone amplifier, speed dialing, etc.
    - ☐ Able to arrange or schedule own transportation with prompting, monitoring, or instruction. May need help dialing phone or looking up bus/van schedule. Uses public transportation only with prompting or regular instruction.
    - ☐ Cannot arrange or schedule transportation at all.

Social Life, Recreation, and Community Activities

►► Answer the following 3 questions **without** thinking about transportation or mobility needs. Check one box for each.

97. Establishes and maintains friendships and supportive relationships – includes making friends and getting in touch with them, by either calling, emailing, in-person at events, work, etc. Excludes any transportation or mobility assistance needed.
    - ☐ Able to establish and maintain friendships independently. May use assistive devices.
    - ☐ Able to establish and maintain friendships only with prompting, encouragement, or social coaching.
    - ☐ Requires assistance to establish and maintain friendships, such as social training or help with dialing a number or signing up for an event.

98. Takes part in leisure activities, hobbies, or recreation in his/her home or residence – includes any leisure activities done at home, such as TV, music, reading, puzzles, etc. Excludes any mobility assistance needed.
    - ☐ Able to independently take part in leisure activities at home. May use assistive devices.
    - ☐ Able to take part in leisure activities at home only with encouragement, prompting, or monitoring. May need some initial assistance with getting a game out, putting in a video, etc.
    - ☐ Requires continual assistance to take part in leisure activities, hobbies, or recreation at home.

99. Takes part in activities in the community for recreation and enjoyment – includes movies, church, bowling, Special Olympics, dances, etc. Excludes any transportation or mobility assistance needed.
- ☐ Able to independently take part in activities in the community for recreation and enjoyment. May use assistive devices.
- ☐ Able to take part in activities in the community for recreation and enjoyment only with monitoring, prompting, or encouragement. May need some initial assistance with making plans, signing up for an event, etc.
- ☐ Requires continual assistance to take part in community activities for recreation and enjoyment.

100. How often does the person typically take part in activities in the community for recreation or enjoyment?
- ☐ Once a week or more
- ☐ Once or twice a month
- ☐ One to eleven times a year
- ☐ Never

101. What prevents the person from taking part in more activities in the community for recreation and enjoyment? Check **all** that apply.
- ☐ Low motivation or interest
- ☐ Behavioral or emotional concerns
- ☐ Social skills limitations
- ☐ Health concerns
- ☐ Money or cost concerns
- ☐ Inadequate transportation
- ☐ No one available to accompany the person
- ☐ Lack of available recreation activities
- ☐ Other: _____
- ☐ Nothing prevents person – He/she is happy with current amount of recreation activities

102. Does this person typically take part in educational opportunities in their community, such as adult education, night school, or community college?
- ☐ Yes, at least once a year
- ☐ Yes, but not in the past year
- ☐ No

Comments about transportation or social or community activities:

Person's Own Caregiving Responsibilities

103. Is this person a primary caregiver for another person?
- ☐ No
- ☐ Yes → What is his/her relationship to the person he/she is taking care of? _____

Person's Own Parental Responsibilities

This section concerns any parental responsibilities the person has themselves.

104. Does this person have any children?
- ☐ No → **If No, Skip to Question 106**
- ☐ Yes

105. Please check one box or fill in the blank for each one:

	Yes	No
a. Are any of this person's own children under age 18?	☐	☐
b. Is this person the primary caregiver for any of his/her children?	☐	☐
c. Does this person have legal custody of any of his/her children?	☐	☐
d. Is another agency involved in the care or protection of any of this person's children?	☐	☐
e. Is there a secondary caregiver for these children?	☐	☐

f. If there is a secondary caregiver, how is he/she related to the person?

_____

☐ There is no secondary caregiver

Primary Caregiver Support (Unpaid)

Primary caregivers provide **unpaid**, direct support for the person and are usually responsible for the person's care. They are typically parents or close relatives with whom the person lives, or a Host Home provider. This does not include Supported Living or group home staff.

106. Is this person his or her own primary caregiver?
- ☐ Yes → **Skip to Question 111**
- ☐ No

107. Does this person have an unpaid primary caregiver?
- ☐ No → **Skip to Question 111**
- ☐ Yes

108. How is the primary caregiver related to this person? Check only one.
- ☐ Person's spouse or unmarried partner
- ☐ Parent
- ☐ Sibling
- ☐ Grandparent
- ☐ Host Home provider
- ☐ Other: _____

109. How is the secondary caregiver related to this person? Check only one.
- ☐ Person has no secondary caregiver
- ☐ Person's spouse or unmarried partner
- ☐ Parent
- ☐ Sibling
- ☐ Grandparent
- ☐ Host Home provider
- ☐ Spouse or partner of primary caregiver
- ☐ Other: _____

110. Check the box in the first column if any of the following apply to the primary unpaid caregiver. Information may be obtained from the caregiver, other team or support staff members, or the person's record. Check any in the second column that apply to the secondary unpaid caregiver (such as when two caregiving parents). If no secondary caregiver, leave the second column blank. **Do not include any paid caregiving support.** Check all that apply.

	Unpaid Caregiver Profile	**Primary Caregiver**	**Secondary Caregiver**
a.	Caregiver is employed 20 hours a week or more	☐	☐
b.	Caregiver works during hours this person needs support	☐	☐
c.	Caregiver is age 65 - 74	☐	☐
d.	Caregiver is age 75 - 80	☐	☐
e.	Caregiver is age 81 or older	☐	☐
f.	Caregiver is also primary caregiver for aging parents, ill spouse, or other relative with disabilities	☐	☐
g.	Caregiver is also caring for an additional child or children who are under the age of 18 and who live with them	☐	☐
h.	Caregiver is frail or has poor health affecting ability to give care	☐	☐
i.	Caregiver cannot drive or has no car	☐	☐
j.	Caregiver limits driving to only around town or cannot drive at night	☐	☐
k.	Caregiver has memory problems affecting ability to give care	☐	☐
l.	Caregiver does not speak English	☐	☐
m.	Caregiver has a physical or mental health disability affecting ability to give care	☐	☐
n.	Caregiver has an intellectual disability affecting ability to give care	☐	☐

Other Unpaid Supports

111. Does the person have any other people who provide **unpaid** regular support or assistance at least once a month? This does not include anyone providing paid support or assistance. Check all that apply.
- ☐ Person has no regular, unpaid natural supports
- ☐ Parent or sibling
- ☐ Other family member: _____
- ☐ Friend
- ☐ Roommate
- ☐ Co-worker
- ☐ Neighbor/Member of his/her religious organization
- ☐ Unrelated guardian, conservator, or legal advocate
- ☐ Other: _____

Comments about unpaid caregiving supports:

Any other concerns

112. Include here any other concerns or considerations not captured elsewhere on this tool which impact this person's need for support:

Information about person(s) filling out this form

Name of person filling out form:	Relationship to the individual:	Work / Day Number:	Date completed:
	Service Coordinator		

The development of this assessment tool has been sponsored in part through an *Independence Plus* Systems Change Grant (11-P-92079/1-01) funded by the Centers for Medicare and Medicaid Services.

	Level of Need (LON) Application	Effective Date: November 7th, 2011

Developmental Disabilities Administration

1.0 Accessing the LON Application

Website: http://mrdda.dc.gov/lon/login.aspx

To login to the application:

Please use your current MCIS ID and Password to access the system. By default, you will have access to the same individuals that appear in MCIS.

Important Note:

The application will end the session once the 2 hour timer expires. To avoid any potential loss of data, please save in regular intervals.

2.0 Using the LON Application

1. To begin using the tool, select a client just as you would in MCIS.
2. Once the client loads, any assessments that have been started or completed will be displayed.
3. Providers can update/view assessments by clicking on the button next to the assessment and then selecting the following:

    a. Edit - Selecting this button will open the assessment and allow you to make changes to be saved. You can save or cancel your changes by clicking the appropriate button in the upper right hand corner Save Cancel

    b. View - Selecting this button will open the assessment in read only mode. Changes/updates will not be allowed.

4. Providers can view summary reports by selecting the following:

    a. Report - Selecting this button will display the assessment summary report. This can only be run for assessments that have a status of completed.

    b. Risk Analysis Report - Selecting this button will display the risk analysis based on the assessment. This can only be run for assessments that have a status of completed.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Title/Subject: **Level of Need Assessment and Screening Tool Procedure**
Policy (cross-referenced to): Level of Need Assessment and Screening Tool Policy

All underlined words/definitions can be found in the Definitions Appendix.

1. PURPOSE

The purpose of this procedure is to establish the standards and guidelines by which the Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), will complete the Level of Need Assessment and Screening Tool on at minimum an annual basis as part of the person-centered planning process.

2. APPLICABILITY

This policy applies to all DDA employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of individuals with disabilities receiving services as part of the DDA Service Delivery System funded by DDA or the Department of Health Care Finance (DHCF).

3. PROCEDURES

The following are the standards by which DDS will implement this policy:

A. Initial Level of Need Assessment and Screening Tool (LON)

1. At the time the ISP meeting is scheduled, the DDA Service Coordinator initiates the creation of an LON in the LON web application. Once created, all team members registered with MR/DDA Consumer Information System (MCIS) are notified that the LON is ready for completion.
2. The residential and day/vocational service providers, if applicable, are expected to complete the sections of the LON tool for the individual based on the support needs of the person in those respective settings.
   a. The DDA Service Coordinator will complete the LON tool through interviews with the individual's natural supports for those who live on their own or in a natural home.
   b. The health, behavioral and psychiatric sections of the tool can be completed by the individual clinician, or, the residential or day/vocational service provider or DDA Service Coordinator based on review of written assessments, treatment plans, medical records, and Health Management Care Plans completed by a nurse, physician, PT, OT, SPL, Dietician, Nutritionist, and/or Behavioral Psychologist.
   c. After each team member completes a section of the LON, the tool should be saved and printed by the team member. The tool can be modified by a subsequent team member which will override previous entries until finalized by the DDA Service Coordinator.
3. The DDA Service Coordinator must review the results of the LON tool with all team members during the pre-ISP meeting/case conference to verify that all questions have

been completed and that there is agreement with the LON tool responses by all members of the team.

4. Once all team members agree on the responses, the DDA Service Coordinator "commits" the LON tool in the web application.
5. Once committed, the LON reports are available to all team members by selecting the "report" button and the "risk analysis" button in the web application.
6. The LON produces a two reports that illustrates:
   a.) a chart of the individual's support needs in functional areas as they relate to others supported by the DC DDA service system;
   b.) a list of significant diagnosis and support needs for the ISP team's attention; and,
   c.) a list of potential risks the individual may face that the team must address in the ISP meeting by indicating on the LON risk analysis report how the risk is being addressed.
7. The LON reports must be filed with the ISP in the service provider record and in MCIS.
8. The LON Assessment Tool must be filed in the Assessment section of the service provider record and in MCIS.

B. Update of the LON

1. Any team member may request an update of the LON whenever an individual experiences a significant change in his/her support needs.
2. The team member will request an ISP meeting/case conference via the DDA Service Coordinator, who will then initiate the creation of an updated LON assessment. All team members registered in MCIS will be notified that the LON is ready for completion.
3. All procedures as described in A. above will be followed to update the tool. The last results of the LON on record will be copied and opened for updating by team members during this period.
4. Once reviewed by the ISP team, the DDA Service Coordinator will commit the tool in the web application. The Report results will then be available for the ISP team to utilize in the person-centered planning process.
5. The LON must be updated at least annually at the time of the annual ISP.

DC Level of Need Assessment and Screening Tool Summary Report

Name: _____ Date of Birth: _____ HCBS/ICF/IDD: _____ Date of Assessment: _____

Assessment Summary:

	0	1	2	3	4	5	6	7	8
Health and Medical (Home/Res)									
Health and Medical (Day/Voc/School)									
PICA (Home/Res)									
PICA (Day/Voc/School)									
Behavior (Home/Res)									
Behavior (Day/Voc/School)									
Psychiatric (Home/Res)									
Psychiatric (Day/Voc/School)									
Criminal/Sexual Issues (Home/Res)									
Criminal/Sexual Issues (Day/Voc/School)									
*Seizure									
Mobility									
Safety									
Comprehension and Understanding									
Social Life									
Communication									
Personal Care									
Daily Living									

The higher the result in each area, relative to the maximum, the more likely the person requires an increasing level of support. Those support needs should be considered in the development of the Individual Plan when planning for the achievement of desired personal outcomes.

Name: _____ Date of Birth: _____ HCBS/ICF/IDD _____ Date of Assessment: _____

Additional Domains:

Health and Medical

- ☐ Oxygen (q4)
- ☐ Tube Feeding (q9)
- ☐ Smoke (q17)

- ☐ Grand Mal or Convulsive Seizure (14) (if coded 3 or 4)
- ☐ Auto Immune Disease (q16)
- ☐ Cancer (q16)
- ☐ Chronic Constipation/Diarrhea (q16)
- ☐ Dementia or Alzheimer's Disease (q16)
- ☐ Dental or Gum Disease (q16)
- ☐ Diabetes (oral meds required) (q16)
- ☐ Diabetes (injected meds required) (q16)
- ☐ Dysphagia (swallowing disorder) (q16)
- ☐ Heart Condition (q16)
- ☐ High Blood Pressure (q16)
- ☐ Kidney Disease (requiring dialysis) (q16)

- ☐ Pregnancy (q16)
- ☐ Pulmonary Condition (q16)
- ☐ Severe Allergy or Allergic Reaction (q16)
- ☐ Sleep Apnea (q16)
- ☐ Stroke or CVA (q16)

- ☐ Substance Abuse (current) (q16)
- ☐ Substance Abuse (history of) (q16)
- ☐ Weight Issues (over) (q16)
- ☐ Weight Issues (under) (q16)
- ☐ Two or More Falls in past 3 months (q17)

Medical Care

- ☐ Hands on, direct LPN/RN care (q12)
- ☐ Direct LPN/RN (frequency) (q13a)
- ☐ Direct LPN/RN (intensity) (q13b)
- ☐ Medically Prescribed Special Diet (q17)
- ☐ Medical Devices (q17)
- ☐ Medical Office Visits (q18)

Extra Support

- ☐ Extra Behavior Support in Community(58
- ☐ Extra Support When Traveling in Car(95)

Vehicle

- ☐ Vehicle Modifications Needed (q94)
- ☐ Van with Lift (q93)

Caregiving

- ☐ Primary Caregiver Score
- ☐ Secondary Caregiver Score
- ☐ Primary Parental Responsibility (q104)

Medications

- ☐ Heart Medications/Blood Thinners (q21)
- ☐ Frequent Changes in Medication (q21)
- ☐ Long Term Use of Meds (q21)

Diagnosis

- ☐ Down Syndrome (q15)
- ☐ Other Chromosomal Disorder (q15)
- ☐ Psychotic Disorder (q56)
- ☐ Mood or Personality Disorder (q57)

Risks

- ☐ Refusal of Critical Services (q74)
- ☐ Homeless or Risk of Homelessness (q75)

Incidents in Past 12 Months

- ☐ Emergency Hospitalization (q77)
- ☐ Unusual Incident or Behavior (q77)
- ☐ Suicide Attempt or Gesture (q77)

Other

- ☐ Person is non-English Speaking (q91)
- ☐ Overnight Support (q84)
- ☐ Home Modifications (q73)

Name: _____ Date of Birth: _____ HCBS/ICF/IDD _____ Date of Assessment: _____

Potential Risk: The following areas were identified in this assessment and screening as having the potential for risk and must be addressed in the person's Individual Service Plan. This may include the identification of a needed assessment or evaluation, and associated step in the action plan to obtain that assessment or evaluation; reference that current supports, guidelines, or a protocol are in place to address the need; specific notation of the team's review in the personal profile of the plan, or recommendations if any for additional supports, training, or sharing of information.

Area of Support	Potential Risk as a Result of:	Strategies to Address Identified Risk:										
		Fact Sheets Educational Materials	Staffing/Supervision (supports	Enhanced Staffing	Written Guidelines or Protocols	Self/Staff Training	Periodic Monitoring	Professional Assessment	Nursing Care Plan	Clinical Services	Natural Supports	Other
Health and Medical	• Catheter • Needle injection • Inhalation therapy or nebulizer • Oxygen • Respiratory suctioning • Wound Care • Ostomy • Tracheostomy • Tube feeding • Artificial ventilator • Chronic constipation/diarrhea • *Dysphagia (swallowing disorder) • Pressure ulcer • Severe allergy or allergic reaction • Substance abuse – current • *Requires food or liquid to be in particular consistency or size • History or risk of dehydration • Two or more falls within past 3 months • Medication/s require careful monitoring for side effects • Heart medications or blood thinners • Prescribed addictive medication • Long-term use of a psychotropic drug • Other medication risk											

Name: ____ _____ Date of Birth: _____ HCI CF/IDD: _____ Date of Assessment: _____

Area of Support	Potential Risk as a Result of:	Strategies to Address Identified Risk:

Area of Support	Potential Risk as a Result of:	Strategies to Address Identified Risk:										
		Fact Sheets Educational Materials	Staffing/Supervision (supports	Enhanced Staffing	Written Guidelines or Protocols	Self/Staff Training	Periodic Monitoring	Professional Assessment	Nursing Care Plan	Clinical Services	Natural Supports	Other
Personal Care	• *Requires hands on assistance for bathing or showering. • *Eats with reminders, prompting, or encouragement. May need assistance with cutting up food or prompting for pace. • Requires hands on assistance with putting food on utensil or requires hand over hand dining assistance. • *Chews or swallows with monitoring, supervision, prompting or encouragement. • Does not walk. Uses wheelchair or scooter independently. • *Does not walk. Uses wheelchair with assistance from another person. • *Changes position in bed/chair with some prompting or encouragement. • *Requires hands on assistance to change position in bed.											

		Fact Sheet, Educational Materials	Staffing/Supervision (supports	Enhanced Staffing	Written Guidelines or Protocols	Self/Staff Training	Periodic Monitoring	Professional Assessment	Nursing Care Plan	Clinical Services	Natural Supports	Other
Behavior	• Severe physical assault or aggression • Bolting • Self-injurious behavior • *Eating or drinking nonfood item (Pica) • *Impulsive food or liquid ingestion • Wandering away • Sexually inappropriate behavior in past year • Criminal concerns in past year • Requires a greater level of support due to behavioral concerns when out in the community											
Safety	• Unable to avoid being taken advantage of financially, sexually and electronically • Danger of accessing a body of water without supervision • Auditory or visual disabilities that require adaptive or assistive devices for safety • Homeless or at risk of homelessness • Refuses critical services • Staff support is frequently absent or tardy or staff is unfamiliar with support needs • Home is not accessible to meet needs • Bedrails • Other safety needs that could cause risk											
Incidents	• Severe injury • Emergency hospitalization • Missing persons report • Victim of assault • Victim of rape • Substantiated abuse or neglect report • Police arrest • Emergency restraint • Injury due to restraint • Unusual incident or behavior • Suicide attempt or gesture											
Other	• Vehicle modifications											

Name: _____ Date of Birth: _____ HCBS/ICF/IDD: _____ Date of Assessment: _____

Name: _____ _____ Date of Birth: _____ HCBS/ICF/IDD: _____ Date of Assessment: _____

	0	1	2	3	4	5	6	7	8
Composite Score (Home/Res)									
Composite Score (Day/Voc/School)									

Current Individual Budgets: Day: $_____ Residential: $_____ Combined: $_____

New Resource Allocation: Day: $_____ Residential: $_____ Combined: $_____

Additional Domains: $_____

Persons Who Contributed to the Assessment:

Name:	Relationship:
	DDA Service Coordinator

* denotes MCIS update required