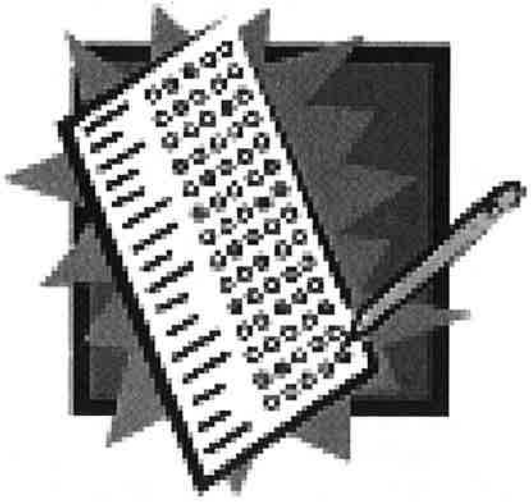
# Level of Need Assessment and Screening Tool Manual



## LON

**November 2011**

## 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.

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

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*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

***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*

## 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.

## 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.

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.

## 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.

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).

### 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.

(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.

**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

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

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:**

**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:

## 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

| Behaviors in past year | At Home or Residence | | | | At Day, School, Job, or Vocational Program | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Support Type | Support Level | Yes | No | Support Type | Support Level |
| 39. Opposes support or assistance<br>Includes resisting care or assistance | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 40. Disruptive behaviors, not aggression<br>Includes any behavior which disrupts or interferes with activities of the person or others. | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 41. Verbal aggression or emotional outbursts<br>Includes verbal threats, name calling, verbal outbursts, and temper tantrums | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 42. Mild physical assault or aggression<br>Does not cause injury, such as pushing, grabbing, or spitting | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 43. Severe physical assault or aggression<br>Can cause injury such as biting, or punching, or attacking | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 44. Property destruction<br>Includes the intentional destruction of property | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 45. Bolting<br>Suddenly running or darting away (excludes wandering away) | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 46. Self-injurious behavior<br>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)<br>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<br>Includes binge eating or compulsive, rapid ingestion of large quantities of food or edible liquids. | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 49. Wandering away<br>Includes wandering away only | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |
| 50. Sexually inappropriate behavior in past year<br>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<br>Includes any criminal justice issues or concerns, or problems with the law | ☐ | ☐ | ____ | ____ | ☐ | ☐ | ____ | ____ |

## 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:

**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:

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 | | |

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 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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**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

# 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: _____

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<br>• Needle injection<br>• Inhalation therapy or nebulizer<br>• Oxygen<br>• Respiratory suctioning<br>• Wound Care<br>• Ostomy<br>• Tracheostomy<br>• Tube feeding<br>• Artificial ventilator<br>• Chronic constipation/diarrhea<br>• *Dysphagia (swallowing disorder)<br>• Pressure ulcer<br>• Severe allergy or allergic reaction<br>• Substance abuse – current<br>• *Requires food or liquid to be in particular consistency or size<br>• History or risk of dehydration<br>• Two or more falls within past 3 months<br>• Medication/s require careful monitoring for side effects<br>• Heart medications or blood thinners<br>• Prescribed addictive medication<br>• Long-term use of a psychotropic drug<br>• Other medication risk | | | | | | | | | | | |

| | | 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<br>• Bolting<br>• Self-injurious behavior<br>• *Eating or drinking nonfood item (Pica)<br>• *Impulsive food or liquid ingestion<br>• Wandering away<br>• Sexually inappropriate behavior in past year<br>• Criminal concerns in past year<br>• 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<br>• Danger of accessing a body of water without supervision<br>• Auditory or visual disabilities that require adaptive or assistive devices for safety<br>• Homeless or at risk of homelessness<br>• Refuses critical services<br>• Staff support is frequently absent or tardy or staff is unfamiliar with support needs<br>• Home is not accessible to meet needs<br>• Bedrails<br>• Other safety needs that could cause risk | | | | | | | | | | | |
| Incidents | • Severe injury<br>• Emergency hospitalization<br>• Missing persons report<br>• Victim of assault<br>• Victim of rape<br>• Substantiated abuse or neglect report<br>• Police arrest<br>• Emergency restraint<br>• Injury due to restraint<br>• Unusual incident or behavior<br>• Suicide attempt or gesture | | | | | | | | | | | |
| Other | • Vehicle modifications | | | | | | | | | | | |

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