Medicaid Functional Eligibility Instrument-Intellectual and Developmental Disability Level-of-Care Adult (MFEI-IDD-LOC-A)

SECTION I: IDENTIFICATION INFORMATION

1. Name and Contact

(first) (middle initial) (last) (Jr/Sr.)

Preferred name

Street Address, Apt #

City, County, State, Zip

Phone Number, primary *Phone Number, alternative*

Email

Mailing Alt. Address (if applicable) Street Address/PO Box, Apt #

City, County, State, Zip

7. Legal Guardian or DPOA Contact *Check all that apply*

☐DPOA, Finances ☐DPOA, Healthcare
☐DPOA, Other/Unspecified ☐ Legal Guardian
☐Designated representative ☐N/A - No Guardian, etc

Name

Relationship

Street Address, Apt #

City, County, State, Zip

Phone Number *Email*

Phone Alternative

2. Assessment Information

a. Program ☐HCBS-IDD ☐ ICF-IID

b. Reason for Assessment

☐Initial Assessment

Is person requesting placement on waitlist? ☐ Yes ☐ No

☐ Annual Reassessment

Was the person's most recent prior MFEI-IDD assessment the youth version (e.g., participant recently turned 18)?

☐Yes ☐No

☐Special Reassessment with permission

If special reassessment, specify rationale:

☐Waiting list – funding now available
☐Waiting list – crisis request
☐Waiting list—exception request
☐Change in condition
☐To/from WORK
☐Other, specify:_____

☐Readmitted

3. Gender ☐Male ☐Female ☐Other (note in comments)

4. Birthdate (Month/Day/Year) ___/____/_____

5. Income Below Poverty Level?

☐ Yes ☐No ☐Unknown

6. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☐ Partner/Significant other
☐ Separated ☐ Divorced

8. ID Information

a. Social Security Number

b. Medicare Number (or comparable railroad insurance number)

c. Medicaid Number

☐ Pending ☐ Not Medicaid Recipient

d. KAMIS ID

9a. Current Payment Sources (check all that apply)

☐ Medicaid ☐Medicare ☐State Aid (e.g., general fund)
☐ Self or family pays ☐TRICARE-ECHO
☐ Private ins., list co:____ ☐Vocational Rehab
☐ Other:_____

b. Eligible for **Veterans' Benefits** ☐Yes ☐No

10. Emergency Contact

Same as Legal Guardian/DPOA (item 7)? ☐Yes ☐No

Name *Relationship*

Street Address, Apt #

City, County, State, Zip

Phone Number *Phone Alternative*

Email

Comments:

11a. Assessor Name/Contact

Assessor Name

CDDO Name

Assessment Reference Date (Month/Day/Year)

Additional persons present at assessment (or attach other documentation of persons present)

Relationship

b. Intake/Referral Date

(eligibility determination letter date, initial assessment only)

___ ___ - ___ ___ - 20___ ___

Month *Day* *Year*

12. Targeted Case Manager

Present at assessment? ☐Yes ☐No

TCM Name

Phone *Agency*

13. Care Coordinator

Present at assessment? ☐Yes ☐No

Care Coordinator Name

Phone *MCO*

14. Ethnicity and Race (check all that apply)

Ethnicity

☐ Hispanic or Latino

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ American Native Hawaiian or other Pacific Islander
☐ White
☐ Other (check only if not listed above)

15. Primary Language

a.	Speaks	Reads	Understands Only
Arabic	☐	☐	☐
Burmese	☐	☐	☐
Chinese	☐	☐	☐
English	☐	☐	☐
Pilipino	☐	☐	☐
French	☐	☐	☐
German	☐	☐	☐
Hindi	☐	☐	☐
Hmong	☐	☐	☐
Korean	☐	☐	☐
Nepali	☐	☐	☐
Sign	☐	n/a	☐
Somali	☐	☐	☐
Spanish	☐	☐	☐
Swahili	☐	☐	☐
Tagalog	☐	☐	☐
Urdu	☐	☐	☐
Vietnamese	☐	☐	☐
Other:_____	☐	☐	☐

b. Communication Methods *Code for primary type of expressive communication*

☐ **Verbal** –i.e., speech
☐ **Nonverbal** –e.g., gestures, sign language, sounds, writing

c. Interpreter used ☐ No

☐Yes, formal staff ☐Yes, family/friend

Comments:

16a. Nature of Intellectual or Developmental Disability
(check all that apply)

☐ 1.Cause Unspecified (i.e., intellectual disability)
☐ 2. Down Syndrome ☐ 3. Autism Spectrum Disorder
☐ 4. Cerebral Palsy ☐ 5. Epilepsy/Seizure Disorder
☐ 6. Fragile X Syndrome ☐ 7. Fetal Alcohol Spectrum Disorder
☐ 8. Brain Injury (injury onset before age 22)

Additional I/DD diagnosis: _____ _____ _____
(list code number(s) from manual)

b. Primary Disability (insert number from above): ____

c. Documented Severity of Intellectual Disability

☐ No intellectual disability ☐ Severe
☐ Borderline ☐ Profound
☐ Mild ☐ Not documented
☐ Moderate

If no intellectual disability, borderline, or not documented, does the person have a developmental disability?
☐ Yes (Continue assessment)
☐ No (Discontinue assessment)

d. Psychiatric Diagnosis (list up to three; DSM IV/V or ICD 9/10 codes can be used; enter n/a if not applicable)

1. Name:_____ Code: _____
2. Name:_____ Code: _____
3. Name:_____ Code: _____

18. Living Arrangement (e.g., current living status)

a. ☐ Alone
☐ With spouse/partner only
☐ With spouse/partner and other(s)
☐ With child (but not with spouse/partner)
☐ With parent(s) or guardian(s)
☐ With sibling(s)
☐ With other relative(s)
☐ With nonrelative(s) (including institutional settings)

b. As compared to 90 DAYS AGO (or since last assessment), person now **lives with someone new**—(e.g., moved in with another person, other moved in)
☐ Yes ☐ No

c. Person feels that s/he would be better off living elsewhere
☐ No
☐ Yes, other community residences ☐ Yes, institution
☐ Not applicable or unknown

d. Relative/informal caregiver feels that the person would be better off living elsewhere
☐ No
☐ Yes, other community residences ☐ Yes, institution
☐ Not applicable or unknown

e. Person resides with an aging caregiver – Primary caregiver(s) is 60+
☐ No ☐ Yes ☐ Unknown

17a. Residential/Living Status at Time of Assessment
(i.e., location of assessment)

☐ 1-Private home/apartment/rented room
☐ Family/kinship home
☐ Owned/rented by individual with I/DD
Is provider owned, but rented by individual with I/DD? ☐Yes ☐No
☐ 2-Host home (e.g., shared living, adult foster care)
☐ 1 person with disabilities
☐ 2 people with disabilities
Is provider owned, but rented by individual with I/DD? ☐Yes ☐No
☐ 3-Group home for IDD
☐ 1-3 people
☐ 4-6 people
☐ 7-8 people
☐ 4-Long-term care facility (nursing homes, including skilled)
☐ State operated
☐ Privately operated
☐ 5-Hospice facility/palliative care unit
☐ 6-Acute care hospital/unit
☐ 7-Rehabilitation hospital/unit
☐ 8-TBI rehabilitation facility (TBIRF)
☐ 9-Psychiatric residential treatment facility
☐ State operated
☐ Privately operated
☐ 10-Nursing facility-mental health
☐ State operated
☐ Privately operated
☐11-Psychiatric hospital/unit
☐ State operated
☐ Privately operated
☐12-Intermediate care facility for individuals with ID (ICF-IID)
☐ State operated
☐ Privately operated
If a private ICF, indicate:
☐ 4-6 people
☐ 7-15 people
☐ 16+ people
☐13-Correctional facility
☐14-Homeless (with or without shelter)
☐15-Other:_____

b. Usual Residence, if different than above (insert number from above): ___

19a. Residential History Over Last 5 YEARS *Code for all institutional settings person lived in during 5 YEARS prior to date case opened (item 11b)* (initial assessment only)

- ☐ Long-term care facility –e.g., nursing home
- ☐ Board and care home, assisted living
- ☐ Semi-independent living
- ☐ Group home
- ☐ Psychiatric residential treatment facility
- ☐ Psychiatric hospital or unit
- ☐ Setting for persons with intellectual disability (e.g., ICF-IID)
- ☐ Traumatic Brain Injury Rehabilitation Facility
- ☐ Correctional facility
- ☐ Unknown
- ☐ None

b. Number of Years (Lifetime) Spent in an Institutional Setting for Individuals with I/DD (e.g. ICF-IID; psychiatric facility; nursing facility) (initial assessment only): _____

Code 00 if person was never in an institutional setting.
Code 99 if unknown.
If less than 1 year, enter as 1.

c. Age at which person left family home: _____
(initial assessment only)
Code 88 if not applicable (i.e., person never left family home).
Code 99 if unknown.

20a.Employment status

☐1-10 hours, weekly ☐11-20 hours, weekly
☐21-30 hours, weekly ☐31-40 hours, weekly
☐41+ hours, weekly ☐Not employed

b. Employment Arrangements (exclude volunteering) (check all that apply)

- ☐ Sheltered Employment/Work Activity (not integrated)
- ☐ Day Habilitation/Day Training
- ☐ Vocational Rehabilitation
- ☐ Supported Employment
- ☐ Competitive Integrated Employment – Individual
  - ☐ With on-the-job supports
  - ☐ Without on-the-job supports
- ☐ Competitive Integrated Employment – Group
- ☐ No employment/training activity, but interested in
  Referral made? ☐No,
  ☐Yes, specify agency/program:_____
- ☐ No employment/training activity, and not interested in

21. Involvement in Structured Activities

a. Volunteerism –e.g., for community services
☐ No ☐ Yes ☐ No, but interested in

b. Formal Education Program
☐ No ☐ Yes ☐ No, but interested in

22a. Disaster Risk (check all that apply)
(i.e. requires first response during emergencies)

- ☐ Electric
- ☐ Cognitive/mental health Issues
- ☐ Physical impairment
- ☐ No informal support
- ☐ Medication assistance
- ☐ None

b. Phone Access
☐Yes ☐No ☐Intermittent

c. Internet Access
☐Yes ☐No ☐Intermittent

23. Verify Accuracy of Pre-Filled information
(software only)

- ☐ Accurate (no updates needed
- ☐ Updates needed (indicate in notes and update person admin in KAMIS)

Comments

24. Person's Expressed Goals of Care (*Enter major goals in large box below, enter primary goal in small boxes at bottom)*

SECTION II: HEALTH

1. Medical Diagnoses* (Include chronic/ongoing conditions that have been diagnosed by a medical professional only; do not include temporary conditions; do not include I/DD conditions as these should instead be captured in section 1, 10a)

a. Respiratory (e.g., asthma, emphysema, cystic fibrosis, chronic obstructive pulmonary disease (COPD), bronchiectasis, chronic bronchitis, fibrosis)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

b. Cardiovascular (e.g., heart disease, high/low blood pressure, arteriosclerosis, Raynaud's Disease, high cholesterol)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

c. Gastro-Intestinal (e.g., ulcers, colitis, liver and bowel difficulties, celiac disease, irritable bowel syndrome, diverticular disease, cirrhosis, hepatitis, gall stones)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

d. Genito-Urinary (e.g., kidney problems, diabetes, neurogenic bladder)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

e. Neoplastic Disease (e.g., cancer, tumors, carcinomas)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

f. Neurological Diseases (e.g., MS, ALS, Huntington's disease, narcolepsy, Parkinson's Disease, muscular dystrophy, dementia, stroke)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

g. Psychiatric Diagnoses (e.g., mood disorder, anxiety disorder, psychotic disorder, substance use disorder)
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

h. Other diagnoses; specify (include any other diagnoses that do not fit into the above categories; exclude I/DD diagnoses) *Specify other diagnoses*: _____
☐Not Present ☐Present, receiving active treatment** ☐Present, monitored but no active treatment

**Must be able to document; active treatment must include *either*: ongoing medical care, on-going staff support, *or* maintenance medications.

2a. History of Epileptic Seizures*
☐Yes (seizure and/or seizure treatment in the past 5 yrs)
☐ No (no seizures and no treatment for seizures in the past 5 yrs)

b. Seizure type, in past year *Check all that apply*
☐No seizures this year ☐Simple partial (simple motor movements affected; no loss of awareness)
☐Complex partial (loss of awareness) ☐ Generalized –Absence (Petit mal)
☐Generalized-Tonic-Clonic (grand mal) ☐Had some type of seizure – not sure what type

c. Seizure Frequency in past year, involving loss of awareness/consciousness
☐ None during past year ☐ Less than once a month
☐ About once a month ☐ About once a week
☐ Several times a week ☐ Once a day or more

3. Inpatient Acute Hospital with an Overnight Stay* (do not include ER visits)
a. Number of admissions within the last 90 days: ____
b. Number of admissions 91-365 days ago:_____

4. Missed More than a Total of Two Weeks of Regular Activities Due to Medical Conditions During the Last Year* (e.g. employment, day programs, school, etc.):
☐Yes ☐ No

5. Presently Requires Caregiver Trained in Special Healthcare Procedures:* (e.g., ostomy care, respiratory, positioning, adaptive devices; Note that this refers to *healthcare* procedures only – do not include behavioral or communication procedures)
☐Yes ☐ No

6a. Mode Of Nutritional Intake
☐ Normal – Swallows all types of food
☐ Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
☐ Requires diet modification to swallow solid food –e.g., mechanical diet (e.g., pureed, minced) or only able to ingest specific foods
☐ Requires modification to swallow liquids –e.g., thickened liquids
☐ Can swallow only pureed solids –AND—thickened liquids
☐ Combined oral and parenteral or tube feeding
☐ Nasogastric tube feeding only
☐ Abdominal tube feeding –e.g., PEG tube
☐ Parenteral feeding only – Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
☐ Activity did not occur –During entire period

b. Any Special Dietary Requirements *(e.g., low-sodium)
[Note: Exclude allergies or modifications captured under 6a]
☐Yes ☐No
If "Yes":
- Specify dietary need:_____
- Doctor/dietician/nutritionist/nurse ordered?
  ☐Yes ☐No
- Requires staff support? ☐Yes ☐No

c. Food Allergies* ☐Yes ☐ No
If "Yes":
- Specify food allergy :_____
- Verified by a medical professional?
  ☐Yes ☐No
- Requires staff support? ☐Yes ☐No

7a. Number and Type of Medications* *List current number of medications by type below*

Antipsychotic: __ __ Diabetes: __ __
Antianxiety: __ __ Sedative/Hypnotic: __ __
Antidepressant: __ __ Anticonvulsant: __ __
Other prescription maintenance medications: __ __ **Total:** __ __
Specify if other(s): _____

b. Off-label prescription medications* *Complete for initial assessments only*

☐ None/not applicable
☐ Yes; Specify medication and off-label use:_____
_____

8. Medication Route of Administration and Support Needs*

Route *Indicate if person currently takes a prescribed medication by this route*	**Indicate level of support needed for medicines taken by this route** *Only complete for routes that are marked yes*	
Oral/Sublingual ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Topical/Transdermal ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Nasal/eye/ear ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Injection** (intramuscular or subcutaneous) ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
IV/Enteral Tube ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Rectal ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Inhalation ☐Yes ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence
Other ☐Yes, list:_____ ☐No/not applicable	☐Independent ☐Hands-on assistance, partial	☐Supervision, cueing ☐Total dependence

**Do NOT count occasional injections that are only provided at a medical/dental clinic; for example, do not count annual flu shots or anesthesia injections that are only provided for the purpose of completing a medical/dental procedure (e.g., Versed, Novocaine). Injections should only include routine maintenance medications that are delivered in the day or residential setting; however, an injection/infusion can be counted if it is occurring at least once every 3 months and requires staff support to accompany the person to the clinic.

9. Most Severe Pressure Ulcer

☐ No pressure ulcer
☐ Any area of persistent skin redness
☐ Partial loss of skin layers
☐ Deep craters in the skin
☐ Breaks in skin exposing muscle or bone
☐ Not codeable –e.g., necrotic eschar predominant, consumer does not know and no documentation, etc.

10. Additional assistance needed during healthcare appointments* e.g., Individual requires staff assistance and/or medication to help manage their physical, cognitive, or behavioral support needs during healthcare or dental appointments (check all that apply)

☐Yes, staff support
If yes: ☐1-person support ☐2-person support
☐Yes, medication support (e.g., sedatives, anti-anxiety)**
☐No/none

**Do not include any medications already captured in item 7a above

Comments:

SECTION III-A: ADAPTIVE – Communication, Cognitive, and Motor Skills

11. Making Self Understood (Expression) *Expressing information content – verbal and nonverbal*

- ☐ **Understood** – Expresses ideas without difficulty
- ☐ **Usually understood** – Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- ☐ **Often understood** – Difficulty finding words or finishing thoughts AND prompting usually required
- ☐ **Sometimes understood** – Ability is limited to making concrete requests
- ☐ **Rarely or never understood**

12. Ability to Understand Others (Comprehension) *Understanding verbal information content (however able; with hearing appliances normally used)*

- ☐ **Understands** – Clear comprehension
- ☐ **Usually understands** – Misses some part / intent of message BUT comprehends most conversation
- ☐ **Often understands** – Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- ☐ **Sometimes understands** – Responds adequately to simple, direct communication only
- ☐ **Rarely or never understands**

13. Hearing *Ability to hear (with hearing appliance normally used)*

- ☐ **Adequate** –No difficulty in normal conversation, social interaction, listening to TV
- ☐ **Minimal difficulty** – Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away
- ☐ **Moderate difficulty** – Problem hearing normal conversation, requires quiet setting to hear well
- ☐ **Severe difficulty** – Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- ☐ **No hearing** (e.g., clinically deaf or profound hearing loss)

14. Vision *Ability to see in adequate light (with glasses or other visual appliance normally used)*

- ☐ **Adequate** – Sees fine detail, including regular print in newspaper / books
- ☐ **Minimal difficulty** – Sees large print, but not regular print in newspapers / books
- ☐ **Moderate difficulty** – Limited vision; not able to see newspaper headlines, but can identify objects
- ☐ **Severe difficulty** – Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- ☐ **No vision**

15. Reading* *Ability to understand non-vocal written material*

- ☐ **Complete independence** - completely able to read/understand complex, lengthy paragraphs
- ☐ **Modified Independence** - able to read complex passages, but may show reduced speed/ retention
- ☐ **Standby prompting** - able to read/understand short, simple sentences but increased difficulty with length or complexity
- ☐ **Minimal prompting** - able to recognize single words and familiar short phrases
- ☐ **Moderate prompting** - able to recognize letters, objects, forms, etc.; able to match words to pictures; with 50-75% accuracy
- ☐ **Maximal prompting** - able to match identical objects, forms, letters (25- 49% accuracy) but may require cues.
- ☐ **Total Assist** - unable to consistently match or recognize identical letters, objects or forms (under 25% accuracy).

16. Writing* *Includes spelling, grammar, and completeness of written communication*

- ☐ **Complete independence** - able to write with average accuracy in spelling, grammar, punctuation, etc.
- ☐ **Modified Independence** - able to accurately write, may have occasional spelling or grammatical errors
- ☐ **Standby prompting** -able to write phrases or simple sentences; evidences spelling, grammar, syntax errors
- ☐ **Minimal prompting** -able to write simple words, occasional phrases; errors and reduced legibility evident
- ☐ **Moderate prompting -** able to write name/family words, cueing may be required; legibility poor
- ☐ **Maximal prompting** - able to write some letters spontaneously; able to trace/copy letters/numbers
- ☐ **Total Assist** - unable to copy letters or simple shapes

Comments:

17. Gross Motor Skills *Ability to perform skills requiring balance and large muscles of the body in coordinated movement (e.g., jumping, kicking a ball, catching a ball)*

☐**Adequate** – Performs skills with satisfactory speed and quality of movement both indoors and outdoors (including uneven ground)

☐**Minimal difficulty** – slight difficulty maintaining balance or controlling limb movement (e.g. appears clumsy, slower movements)

☐**Moderate difficulty** – Noticeable deficits in balance and controlling limb movements (e.g., frequently stumbles, drops objects, walks into objects)

☐**Severe difficulty** – limitations in trunk, head, and limb control resulting in severe difficulty with coordination of own movements (e.g., unable to reach for a glass of water without knocking it over)

☐**No ability to move body** (full paralysis)

18. Fine Motor Skills *Ability to perform coordinated movements that involve small muscles (e.g., grasping a pencil, managing buttons, using scissors)*

☐**Adequate** – Performs movements within appropriate time frame or with appropriate quality of movement

☐**Minimal difficulty** – Slight difficulty controlling movements (e.g., somewhat slow or easily fatigued)

☐**Moderate difficulty** – Noticeable deficits in fine motor skill development (e.g., unable to hold pencil properly and produce legible writing)

☐**Severe difficulty** – Severe limitation in ability to coordinate small muscle movements (e.g., significant struggle to pick up an object using thumb and forefinger)

☐**No ability to move body** (full paralysis)

19. Primary Mode of Locomotion

☐ **Walking, no assistive device**

☐ **Walking, uses assistive device** –e.g., cane, walker, crutch, pushing wheelchair

☐ **Wheelchair, scooter**

☐ **Non-ambulatory** - e.g., stays in bed, uses gurney

20. Falls (in last 6 months)

a. In the last 30 days

☐No falls ☐One fall ☐Two or more falls

b. 31-90 days ago

☐No falls ☐One fall ☐Two or more falls

c. 91-180 days ago

☐No falls ☐One fall ☐Two or more falls

21. Cognitive Skills for Daily Decision Making *Making decisions regarding tasks of daily life – e.g., when to get up or have meals, which clothes to wear or activities to do, how to navigate home and community, ability to make informed choices regarding health.*

☐ **Independent**—decisions consistent, reasonable, and safe

☐ **Modified independence**—Some difficulty in new situations only

☐ **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times

☐ **Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times

☐ **Severely impaired**—Never or rarely makes decisions

☐ **No discernable consciousness, coma**

22. Susceptibility to Victimization* *Ability to protect self against abuse and exploitation by others, including financial exploitation, sexual abuse, emotional abuse, etc. Ability to seek appropriate help when such dangers arise.*

☐ **Independent**—interactions with others are consistent, reasonable, and safe

☐ **Modified independence**—Some difficulty in new situations only (e.g., meeting new people or in unfamiliar environments)

☐ **Minimally impaired**—In specific recurring situations, interactions with others become poor or unsafe; cues / supervision necessary at those times

☐ **Moderately to severely impaired**—interactions with others *consistently* poor or unsafe; cues/supervision required at most/all times

23. Safety Judgement in Emergency Situation* *Ability to recognize an emergency situation and respond appropriately, including medical emergencies, fire, natural disasters, etc. -- e.g., knows how and when to call 911; ability to follow emergency protocols; ability to safely evacuate self.*

☐**Independent** – e.g., person independently recognizes & responds appropriately to an emergency; may use assistive devices

☐**Supervision/Cueing** -- e.g., ability to follow verbal instructions during an emergency

☐**Hands-On Support** -- e.g., person needs hands-on assistance to follow emergency protocols

☐**Total Dependence** – e.g., person unable to recognize or respond to an emergency in any capacity; completely dependent on others for evacuation

24. Persistent Behavior Patterns that Hinder Socialization

a. Narrowly restricted range of interests – e.g., constantly talks about trains

☐Yes ☐No

b. Excessive preoccupation with an activity or routine

☐Yes ☐No

c. Demonstrates lack of social and emotional conventions when socializing –e.g., lack of eye contact

☐Yes ☐No

d. Extreme shyness –e.g., severe inhibition in familiar social situations

☐Yes ☐No

SECTION III-B: ADAPTIVE – IADLs and ADLs

25. Independent Activities of Daily Living (IADLs)

Code for PERFORMANCE (P) in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY (C) based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. Independent – No help, set-up, or supervision
1. Set-up help only
2. Supervision – Oversight / cueing
3. Limited assistance – Help on some occasions
4. Extensive assistance – Help throughout task, but performs 50% or more of task on own
5. Maximal assistance – Help throughout task, but performs less than 50% of task on own
6. Total dependence –Full performance by others during entire period
8. Activity did not occur – During entire period (DO NOT USE THIS CODE IN SCORING CAPACITY)

	P	C
a. Meal Preparation – How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)		
b. Ordinary housework – How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. Managing finances – How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored		
d. Managing medications – How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments; includes prescription and non-prescriptions)		
e. Phone use – How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. Use of technology – e.g., gets on the internet; using the computer to play games, do homework, or for work; use of smart phone apps		
g. Shopping – How shopping for food and household items is performed (e.g., selecting items, paying money) – EXCLUDE TRANSPORTATION		
h. Transportation – How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, in and out if vehicles)		

Comments:

26. Activities of Daily Living (ADL) Self-Performance

- Consider all episodes over 3-day period.
- If all episodes are performed at the same level, score ADL at that level.
- If any episodes at level 6, and others less dependent, score ADL as 5.
- Otherwise, focus on the three most dependent episodes (or all episodes if performed fewer than three times).
- If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5. *Consult decision tree in field manual for assistance with above instructions*

0. Independent – No physical assistance, set-up, or supervision in any episode
1. Independent, set-up help only – Article or device provided or placed within reach, no physical assistance or supervision in any episode
2. Supervision – Oversight / cueing
3. Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight
4. Extensive assistance – Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5. Maximal assistance – Weight-bearing support (including lifting limbs) by 2+ helpers – OR – Weight-bearing support for more than 50% of subtasks
6. Total Dependence – Full performance by others during all episodes
8. Activity did not occur during entire period

	P
a. Bathing – How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, feet, chest, abdomen, perineal area – EXCLUDE WASHING OF BACK AND HAIR	
b. Hair washing* – How washes hair, including applying shampoo/conditioner, keeping shampoo out of eyes, completely rinsing shampoo.	
c. Personal hygiene – How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands – EXCLUDE BATHS AND SHOWERS	
d. Dressing upper body – How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.	
e. Dressing lower body – How dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, compression socks, shoes, fasteners, etc.	
f. Locomotion – How moves between locations on same floor (walking or wheeling). If in wheelchair, self –sufficiency once in chair	
g. Transfer toilet – How moves on and off toilet or commode	
h. Toilet use – How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes – EXCLUDE TRANSFER ON AND OFF TOILET	
i. Menstrual cycle* – Does individual have an active menstrual cycle? ☐ No (skip to 18j) ☐Yes (proceed with this item) --- How individual manages menstrual cycle hygiene, including cleansing self and use of menstrual products; rate according to most recent period rather than the 3-day look back.	
j. Bed mobility – How moves to and from lying position, turns from side to side, and positions body while in bed	
k. Eating – How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
l. Transfers – how moves between surfaces, to / from bed, chair, wheelchair, standing position – exclude bath / shower and toilet transfers	

m. Additional assistance needed in any of the following* (as compared to actual performance in the last 3 days, as rated above)**:**

☐ Bathing/Hair Washing ☐Hygiene ☐ Dressing, upper ☐ Dressing, lower
☐ Toilet use/Menstrual Cycle/Toilet Transfer ☐ Eating ☐ None, N/A

Explanatory note required for each ADL area checked

Comments:

SECTION IV: MALADAPTIVE

27. Behavioral Symptoms and Support Needs

interRAI Code
Code for indicators observed, irrespective of the assumed cause.

- **0** Not present (*No recent history, no supports in place or needed)*
- **1** Present but not exhibited in last 3 days (*Includes history of behavior with supports currently needed)*
- **2** Exhibited on 1-2 of last 3 days
- **3** Exhibited daily in last 3 days

Support Required* –
Type of support **typically** required during person's waking hours:

- **0** No support needed or can ignore behavior
- **1** Monitor only, using a person or through environmental means
- **2** Verbal or gestural distraction or prompting typically required
- **3** One person hands-on support typically needed
- **4** More than one person (2:1) typically needed to redirect

Support Level* –
Level of support **typically** needed to manage behavior during person's 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 arm's length for behavioral support

**Support Required and Support Level is not limited to the 3-day look-back, but rather relies on a "typical" standard.*

	interRAI code	Support Required	Support Level
	Complete for all items	*Complete only for items with interRAI Code 1-3*	
a. Wandering – Moved with no rational purpose, seemingly oblivious to needs or safety			
b. Elopement -- attempts to or exits/leaves home/work/school, etc. at inappropriate times, without notice/permission			
c. Verbal abuse – e.g., others were threatened, screamed at, cursed at, posting abusive comments on social media			
d. Physical abuse –e.g., others were hit, shoved, scratched			
e. Sexual abuse – e.g., others were molested or sexually abused			
f. Socially inappropriate or disruptive behavior –e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings, repetitive oppositional statements, repetitive behavior that interferes with normal activities			
g. Inappropriate public sexual behavior or public disrobing			
h. Resists care – e.g., taking medications / injections, ADL assistance, eating, hygiene			
i. Self-injurious behavior – e.g., banging head on wall; pinching, biting, scratching, hitting, or punching self; pulling own hair, cutting			
j. Destructive behavior toward property– e.g., throwing objects, turning over beds or tables, vandalism			
k. Outbursts of anger – Intense flare-up of anger in reaction to a specific action or event (e.g., upset with decisions of others)			
l. Pica – Ingestion of non-food items (e.g., soap, dirt, feces)			
m. Polydipsia – Inappropriate or excessive fluid consumption (e.g., drinks fluids many times during the day, drinks a huge amount at a time, refuses to stop drinking, drinks secretly from unusual sources)			
n. Stealing –e.g., theft from family or housemates; shoplifting			
o. Bullying others – Pattern of repeated oppression or victimization of others			
p. Cruelty to animals – Deliberate mistreatment of or physical injury to animals [Exclude behaviors that are consistent with cultural norms]			

28. Overnight Behavioral Support* – **Does the** person have behaviors that require support during the sleeping hours

☐No
☐Yes

If yes, indicate typical level of support needed:

☐ Monitor only, using a person or through environmental means
☐ Verbal or gestural distraction or prompting typically required
☐ One person hands-on support typically needed
☐ More than one person (2:1) typically needed to redirect

29. Extreme Behavior Disturbance- History of extreme behavior(s) that suggest serious risk of harm to self (e.g., severe self-mutilation) or others (e.g., fire setting, homicide)

☐ No
☐ Yes, but not exhibited in last 7 days
☐ Yes, exhibited in last 7 days

If yes –
Describe behavior(s):_____
_____
Explain supports/response needed: _____
_____
_____

30. Behavior Problems Prevent Individual from Moving to a Less Restrictive Setting*:

☐Yes ☐No

Note: This must be a recognized behavior problem that is occurring with some frequency, documented in a support plan, and the current environment is helping to lessen. Do not select "yes" based on the belief the person might engage in a behavior in a different environment.

31. Does individual's Written Behavior Plan meet the following criteria (if applicable)? (Check all that apply)

☐ Is specific to the individual
☐ Clearly define the behavior
☐ Clearly define needed supports
☐ Collect information on frequency and severity of the behavior for those behaviors that are managed with restrictions or medication.

All 4 criteria must be met.

Has a Written Behavior Plan*: ☐Yes ☐No

The criteria for behavior plans is specified in K.A.R. 30-63-23

Comments:

ADDENDUM: EMPLOYMENT

A1. Does this person require the employment addendum be completed?* ☐ Yes (proceed) ☐ No (skip this section)

A2. WORK* Code performance (P) and capacity (C) regarding the job-related activities below. Use a last 3-WORKday look back period; however, if most recent employment was more than 3 months ago, use the 8 code for activity did not occur.

Code for PERFORMANCE (P) in routine activities around the home or in the community during the LAST 3 WORK-DAYS

Code for CAPACITY (C) based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. Independent – No help, set-up, or supervision
1. Set-up help only
2. Supervision – Oversight / cueing
3. Limited assistance – Help on some occasions
4. Extensive assistance – Help throughout task, but performs 50% or more of task on own
5. Maximal assistance – Help throughout task, but performs less than 50% of task on own
6. Total dependence –Full performance by others during entire period
8. Activity did not occur – During entire period (DO NOT USE THIS CODE IN SCORING CAPACITY)

	P	C
a. Understanding Workplace Logistics–Understands the employer's probationary period and wage structure. Knows how to read a pay stub and what to do to get a raise. Understands the grievance procedure. Understands if eligible for benefits and leave time. Understands when and how they will be evaluated. Knows legal rights as an employee.		
b. Adherence to Schedule -- Reliably attends work as scheduled and adapts to changes in schedule. Effectively uses time-clock/reports hours. Understands and carries out correct procedures for using leave time. Follows rules for break-time.		
c. Workplace Interactions -- Able to effectively communicate workplace needs. Engages in acceptable and collegial interactions with supervisors, coworkers, and/or customers. Recognizes professional boundaries. Engages in acceptable social interaction during work-related off-the-clock activities (e.g., break room, office parties, etc.) Reacts appropriately to constructive criticism. Does not unduly distract co-workers/customers and is not easily distracted by them. Adapts to new supervisors/co-workers/customers. Able to remediate or seek help if workplace conflicts occur.		
d. Quality of Work -- Completes work assignments with a quality level that is consistent with that of co-workers. Uses work materials accurately and maintains an orderly and safe work space. Recognizes and corrects mistakes. Demonstrates acceptable appropriate work-quality learning curve when job duties change.		
e. Work Efficiency -- Demonstrates work productivity that is comparable, on average, with that of co-workers. Plans and sequences work tasks, including set-up and close-down activities, in a logical and efficient manner. Adapts, within an acceptable period of time, to changes in the workflow when job duties change.		

A3. RISK OF UNEMPLOYMENT OR DISRUPTED EDUCATION

a. Increase in lateness or absenteeism OVER LAST 6 MONTHS ☐No ☐Yes ☐ Not applicable

b. Poor productivity or disruptiveness at work or school ☐No ☐Yes ☐ Not applicable

c. Expresses intent to quit work or school ☐No ☐Yes ☐ Not applicable

d. Persistent unemployment or fluctuating work history over last 2 years ☐No ☐Yes ☐ Not applicable

e. Poor hygiene* ☐No ☐Yes ☐ Not applicable

f. Other* ☐No ☐Yes ☐ Not applicable
If yes, please describe:

Comments: