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| **General Background** | | |
| Would you prefer to go by your full name or is there a nickname you prefer? |  | |
| Do you have a Guardian or Legal Power of Attorney? | No  Yes | Notes: |
| Do you have Provider Orders for Life Sustaining Treatment (POLST) or some other form of advance directives for your medical care? | No  Yes | Notes: |
| Is there anyone else you would like to participate in your service planning? | No  Yes | Notes: |
| Are there any cultural, traditional, or personal values you would like to celebrate or have your providers support you in observing? | No  Yes | Notes: |
| Do you have a preference on the gender of your caregiver? | Female  Male  No Preference | Notes: |
| Are there any special considerations you want to share, such as preferred call or appointment times? | No  Yes | Notes: |

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| **Family and Home** | | |
| What setting describes your current living situation? (check only one) | Alone  Congregate setting  Institutional setting  Temporary/homelessness  With family  With friends/roommate | Notes: |
| If you selected institutional setting, which institutional setting? | Correctional Facility  Hospital (>30 days)  Institute for Mental Disease (IMD)  Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)  Nursing facility | Notes: |
| What is the anticipated discharge date? |  | Notes: |
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| If you selected congregate setting, which congregate setting? | Assisted Living Facility (ALF)  Boarding Care Home  Group Home  Other:  Transitional Program | Notes: |
| Would you consider your housing arrangement stable? | No  Yes | Notes: |
| Are you concerned about your ability to pay your mortgage or rent, or other household expenses? | No  Yes | Notes: |
| Are you receiving SNAP, Housing subsidy, LIEAP or other non-waiver assistance? | No  Yes | Notes: |
| Do you feel safe and comfortable in your home? | No  Yes | Notes: |

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| Housing and Environment | | |
| Are there home improvements related to safety (such as banister repair, step repair, non-skid surfaces) that are needed? | No  Yes | Notes: |
| Are all appliances, heating and cooling units working? | No  Yes | Notes: |
| Do you have working smoke and carbon monoxide detectors? | No  Yes | Notes: |
| Do you have an emergency plan and contact numbers easily available? | No  Yes | Notes: |
| Are you able to get out of your home easily in an emergency? | No  Yes | Notes: |

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| Community Activities | | |
| How do you like to spend your free time? |  | Notes: |
| Do you feel you have enough social interactions? | No  Yes | Notes: |
| Do you have access to the community as often as you like? | No  Yes | Notes: |
| Are you happy with your current employment, volunteer work, or retirement status? | No  Yes | Notes: |
| Would you like to participate in more community activities such as volunteering, social clubs, cultural/arts, religious activities, physical/leisure, or other community activities? | No  Yes | Notes: |
| Which supports would you want or need to participate in community activities? | Advocacy/Supervision  Mobility assistance  N/A  Other:  Personal Assistance (e.g. meals/using the bathroom)  Transportation | Notes: |
| Are there people in your personal life that assist you with daily activities and household chores? | No  Yes | Notes: |
| If yes, who? | Friend/Neighbor  Guardian/LAR  Other:  Parent  Sibling  Son/daughter  Spouse/Significant other | Notes: |

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| Supported Decision Making | | |
| Are you comfortable making decisions about what you want and explaining those decisions to others? | No  Yes | Notes: |
| Do you know what medication(s) to take every day, and when? Do you remember to take your medication every day? | No  With help  Yes | Notes: |
| Are you able to manage your money and pay your bills? | No  With help  Yes | Notes: |
| If not, is there someone that can help you with this? | No  Yes | Notes: |
| Are you comfortable talking to someone if a caregiver is treating you poorly? Who would you talk to about this? | No  With help  Yes | Notes: |

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| Health and Wellbeing | | |
| Do you participate in any wellness activities, such as taking walks, stretching, or other exercises? | No  Yes | Notes: |
| Do you have food allergies or dietary restrictions? | No  Yes | Notes: |
| In the past 12 months, were you worried that your food would run out before you got money to buy more? | Never  Often  Sometimes | Notes: |
| How do you get to your regularly scheduled appointments? | Drive  Other:  Public Transportation  Ride from family/friends  Taxi/ Ride Share (Uber)  Walk | Notes: |
| Do you need transportation help for non-medical appointments or community events? | No  Yes | Notes: |

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| Goals | |
| What would you like to focus on during waiver services? |  |

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| Case Manager Observations | | |
| The participant demonstrates the ability to ensure their own safety without assistance? | No  Yes | Notes: |
| The participant demonstrates the ability to make decisions about home and friends unassisted? | No  Yes | Notes: |
| The participant is at risk of going without housing or essential utilities? | No  Yes | Notes: |
| Are there any services that could assist this participant in maintaining their home? | No  Yes | Notes: |
| Case Manager Notes: |  | |

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| Functional Assessment Results | |
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| What does a typical day look like for you? |  |