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