

Individual data:

| | | |
|------------------|---------------|------------------------|
| DATE OF MEETING: | DATE CREATED: | DATE FINALIZED: |
| FIRST NAME: | LAST NAME: | |
| GENDER: | MCI: | COUNTY / JOINDER: |
| BIRTH DATE: | CATEGORY: | DATE MAILED TO FAMILY: |

Reason for update or review:

- | | |
|--|---|
| <input type="checkbox"/> Newly eligible | <input type="checkbox"/> In a private ICF or state ID center |
| <input type="checkbox"/> Annual update (regardless of changes in category or supports needed) | <input type="checkbox"/> Change of category only (emergency, critical, planning) |
| <input type="checkbox"/> Change in supports needed only (more or less) – unchanged category | <input type="checkbox"/> Change in category and supports needed |
| <input type="checkbox"/> No longer wishes to receive services or no longer eligible for services | <input type="checkbox"/> Comes off waiting list – needs met by another program (e.g. CHC, another waiver) |

Participant information:

| NAME | ROLE | DATE | SIGNATURE |
|------|------|------|-----------|
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For the following items, indicate the reason for need by answering Yes / No for all questions:

| EMERGENCY NEED (PERSON NEEDS SUPPORTS IMMEDIATELY) | | |
|--|---|--|
| 1 | Death, family crisis, serious illness of a caregiver or caregiver is no longer able to provide care with no other caregivers available. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | Immediate supports (behavioral, day, in-home, or other) will prevent the immediate need for residential support | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | Person has been committed by the court or is at risk of incarceration without supports (could be to a state center, group home or other residential situation) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 | Person is living in a setting or location that places their health or safety at risk and immediately needs a new place to live (e.g. shelter, prison, acute care hospital, or person is homeless) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | Additional supports are needed immediately to protect the person's health and safety or to keep him/her from being placed in a state center, nursing home, large ICF or other congregate care setting due to behavioral needs, physical needs, or other situations. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| EMERGENCY NEED (PERSON NEEDS SUPPORTS IMMEDIATELY) | | |
|--|--|--|
| 6 | Long term (greater than 90 days) supports are needed immediately for (1) family/caregiver to keep the person at home and there is no other caregiver available; OR (2) Person needs immediate support to stay in their own home/family home. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7 | Short term (90 days or fewer) supports are needed immediately for (1) family/caregiver to keep the person at home and there is no other caregiver available; OR (2) Person needs immediate support to stay in their own home/family home. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8 | There are two or more people in the home that require support with their activities or daily living which compromises the caregiver's ability to ensure the person's health and safety. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9 | Person has a single caregiver and supports are needed immediately to ensure the person's health and safety. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10 | Person or family/caregiver needs immediate support to maintain his/her employment situation, obtain follow along supported employment or achieve a post-school employment outcome. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| CRITICAL NEED (PERSON NEEDS SUPPORTS WITHIN TWO YEARS) | | |
|--|---|--|
| 1 | Person has a caregiver age 60+ and will need supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | Person has an ill caregiver who will be unable to continue providing care within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | Person has behavioral support needs or medical concerns or conditions that will warrant additional supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 | Person has personal or physical care needs that cannot be met by current family/caregivers or the person's health has deteriorated and supports will be needed within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | There has been a death or other family crisis (e.g. illness, divorce), requiring additional supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6 | There has been a change in the household that no longer allows the caregiver to provide the level of support previously provided (e.g. new member of the household that requires care and assistance with activities of daily living; deteriorating health of caregiver.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7 | Person or caregiver will need an alternative living arrangement within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8 | Person has graduated or left school in the past five years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9 | Person is graduating from high school within the next two years and will need supports. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10 | Person has a single caregiver and will need supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11 | There are two or more people in the home that require support with their activities of daily living. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12 | Person moved from another county where they were receiving residential, day, or in-home supports (non-waiver funds only). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13 | Person is receiving day supports that are inappropriate to meet their needs. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14 | Person moved from another state where they were receiving residential, day, or in-home supports. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15 | The county/administrative entity has plans to assist the person in moving within the next two years (from a state center, nursing home, state hospital, or other residential setting) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16 | Person is losing eligibility for Children and Youth supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17 | Person is losing eligibility for Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/behavioral health rehabilitation services. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18 | Person is losing eligibility for OBRA/Nursing Home supports within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19 | Person receives services or support for behavioral or medical diagnoses during most of the day or at a very high level. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| CRITICAL NEED (PERSON NEEDS SUPPORTS WITHIN TWO YEARS) | | |
|--|--|--|
| 20 | Person is losing eligibility for Residential Treatment Facility within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21 | Person is losing eligibility for residential supports received in an Approved Private School within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22 | Person is leaving jail, prison, or other criminal justice setting within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23 | Person will need support to stay in their own home/family home within the next two years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24 | Person has been identified as ready for discharge within the next two years (from a state hospital, state center, private ICF, nursing home or other residential setting). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| PLANNING FOR NEED (PERSON'S NEED FOR SUPPORT IS MORE THAN TWO YEARS AWAY BUT LESS THAN FIVE YEARS AWAY) | | |
|---|--|--|
| 1 | Family/caregiver is or will be 60+ years of age and will need supports in the next 2-5 years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | Person lives in a large residential group setting, and person/family has expressed a desire to move (or the county/administrative entity plans to move the person) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | Known need for supports more than two years away. Specify: Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 | Person or family/caregiver will need increased supports in the next 2-5 years. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | Person is losing eligibility for Children and Youth supports within the next 2-5 years. Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6 | Person is losing eligibility for Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/behavioral health rehabilitation services or other mental health/behavioral support (including therapeutic foster care) within 2-5 years. Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7 | Person is losing eligibility for Residential Treatment Facility supports within 2-5 years Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8 | Person is losing eligibility for residential supports provided in an Approved Private School placement within 2-5 years. Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9 | Person will be graduating from high school in the next 2-5 years. Enter date needed (MM/DD/YYYY): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10 | Person lives in a residential setting that is more restrictive than what is needed. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Existing supports and services:

Answer Yes/No for supports that are currently in place specifying whether the supports are ODP or non-ODP supports (Non-ODP supports include education, EPSDT, and community resources).

| INDIVIDUAL SUPPORTS | | |
|--------------------------|--|--|
| Respite Supports 24 Hour | | |
| ODP Supports | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| INDIVIDUAL SUPPORTS | |
|--|--|
| Respite Supports <24 Hour | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Occupational Therapy | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Therapy | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Communication Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Therapies | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Education | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Post Secondary/Adult Education | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| In-Home and Community Supports, Companion or Specialized Skills Development | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Assistive Technology | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Homemaker/Chore Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Environmental Accessibility (e.g. adaptations to home or vehicle) | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Individual Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| TRANSPORTATION | |
| Transportation (including trip/mileage reimbursement, para-transit, etc.) | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| EMPLOYMENT AND DAY SUPPORTS | |
|---|--|
| Senior Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Supported Employment (Career Assessment, job coaching, etc.) | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Community Participation Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adult Day Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Day Supports (e.g. volunteering, community experience) | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| RESIDENTIAL SUPPORTS | |
| Family Living/Life Sharing | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foster Care (Children only) | |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Individual Home Owned/Leased by the person with < 24 hour staff | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Individual Home Owned/Leased by the person with 24 hour staff | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Agency Group Home or Apartment < 24 hour staff | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Agency Group Home or Apartment 24 hour staff | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nursing Home | |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Institution with > 15 people | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| RESIDENTIAL SUPPORTS | |
|---|--|
| State Center | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Private ICF | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Domiciliary Care/Personal Care Boarding Home (Adult Foster Care) | |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Assisted Living | |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Transitional Housing/Respite | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Residential/Housing Supports | |
| ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Non-ODP Supports | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Supports needed:

For the following items, indicate if support is needed by answering yes or no for all questions.

| INDIVIDUAL SUPPORTS | |
|--|--|
| Date of first request in this category (MM/DD/YYYY): | |
| Person needs support overnight to provide a break for the caregiver. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support for a few hours during the day to provide a break for the caregiver. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs behavioral support or services. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs physical therapy to help them increase or maintain their ability to move. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support with difficulty communicating. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs other therapies (e.g. visual/mobility, occupational, music). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support with education beyond high school. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support to learn or maintain skills and to take part in activities at home or in the community. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs an object/device to help them communicate, self-direct, and/or build adaptive capabilities (e.g. assistive technology, adaptive equipment). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support with medical needs not covered by insurance (Certified nursing assistant or nurse). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs modifications to their home or vehicle to access them or for safety and/or independence. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs other individual supports not listed above. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| TRANSPORTATION | |
|---|--|
| Date of first request in this category (MM/DD/YYYY): | |
| Person needs transportation on a daily or almost daily basis. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs transportation every few days or less often. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| EMPLOYMENT OR DAY SUPPORTS | |
|---|--|
| Date of first request in this category (MM/DD/YYYY): | |
| Person needs support upon retirement or in planning their retirement. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support finding or keeping a job. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support with activities that will better prepare them for a job (e.g. learning about work incentives, how to manage medical and cash benefits when working). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support to participate in community activities, including volunteering. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| RESIDENTIAL SUPPORTS | |
|---|--|
| Date of first request in this category (MM/DD/YYYY): | |
| Person needs support that would be best provided by living in another family home with a family trained to provide support (Lifesharing). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs constant support living in a home or apartment an agency owns and operates, with vocational supports. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs support living in a home that they own. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs occasional support living in a home or apartment an agency owns and operates. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs constant support living in a home or apartment an agency owns and operates, without vocational supports. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person needs other housing or residential supports. | <input type="checkbox"/> Yes <input type="checkbox"/> No |