SOUTH CAROLINA Department OF Disabilities AND Special Needs

DDSN Executive Memo

TO: **EXECUTIVE DIRECTORS, DSN BOARDS**
CEOS, QUALIFIED PROVIDER
CASE MANAGEMENT
HASCI CASE MANAGERS/SUPERVISORS

FROM: **SUSAN KREH BECK, ED.S., LPES, NCSP, ASSOCIATE STATE DIRECTOR-POLICY**

DATE: **NOVEMBER 21, 2018**

RE: **Update on Service Assessments for Respite and Personal Care for Medicaid Waiver Services**

Over the past several weeks we have been working hard to revise the service assessments for the waiver programs and incorporate your feedback as much as possible. We received some great feedback on these assessments and based on that feedback have made changes as outlined in Attachment A. The attached documents are the final drafts that will be presented to the SCDDSN Commission for approval in December.

Please take a moment to review them and if there are any glaring issues or problems please communicate with Lori Manos (lmanos@ddsn.sc.gov) or Melissa Ritter (mritter@ddsn.sc.gov) in order to ensure they are addressed.

We are hopeful that the revisions to the assessments have created tools that the provider community, waiver participants, and caregivers can support. Thank you for all your feedback and assistance in revising these tools.

Attachment A:	Change Summary
Attachment B:	Guidance for HASCI Waiver Attendant Care/Personal Assistance
Attachment C:	Guidance for ID/RD and CS Waiver Personal Care/Attendant Care Assessment
Attachment D:	Attendant Care/Personal Assistance Assessment - HASCI Waiver
Attachment E:	Personal Care/Attendant Care Assessment - ID/RD and CS Waiver
Attachment F:	Guidance for Respite Assessment for ID/RD, CS, and HASCI Waiver
Attachment G:	Respite Assessment - HASCI Waiver
Attachment H:	ID/RD and CS Waiver Respite Assessment

CHANGE SUMMARY

Personal Care/Attendant Care/Personal Assistance Assessment:

- We have updated guidance for clarity in many areas that need additional explanation or elaboration.
- We adjusted the labeling of the Personal Care Modifiers in order to help clarify the scoring.
- Where possible we adjusted the responses in the assessment to match the wording of the Case Management Annual Assessment.
- We corrected any typos and clarified unclear wording or responses.
- We added a response to the Meal Preparation question in order to give additional points if food had to be processed after preparation.
- We updated some scoring options to include additional scores and responses.
- We adjusted the responses to remove percentages.

Respite Assessment:

- We received an overwhelming response initially that a measure of caregiver stress should be incorporated; therefore, we have maintained the Caregiver Self-Assessment portion of the assessment. Additional guidance was added for this tool.
- We have updated guidance for clarity in many areas that need additional explanation or elaboration.
- Another item that was extensively requested was to combine the respite exception request with the respite assessment for the ID/RD Waiver. We have included this section in the new assessment, but the policy regarding the exception has not changed. Individuals must meet certain requirements to qualify for the exception.
- We added a Supervision Modifier that allows for the supervision score to be increased if the caregiver is unable to go out in the community or run errands.
- We added additional supplemental questions to add hours when a caregiver also cares for additional family members.
- Where possible we adjusted the responses in the assessment to match the wording of the Case Management Annual Assessment.
- Expanded the “Additional Justification” box to allow for more narrative to be visible.

We also received some feedback that did not result in changes. These included issues regarding the time that it would take when filling out the assessment and having to refer back to a different document for guidance. While there will be a learning curve associated with the use of the guidance, as Case Managers become familiar with the guidance and the assessment, the need to refer to the guidance should diminish.

We also had some concerns regarding the "age appropriate" response in some questions. We encourage the Case Managers to utilize the narrative portion of the assessments if there are situations where they give a score to something that may be generally considered an appropriate activity for someone of that age.

There were questions and concerns regarding the new Caregiver Stress Self-Assessment portion of the Respite Assessment. In order to most accurately measure caregiver stress we decided to utilize a third party tool developed by a reputable association. While this tool will be a form that we are unable to edit, it will be scored by the Case Manager, not the family, and will be verified during the plan review process which we hope will mitigate any confusion. We also added additional guidance to reflect that it should be scored based on a "typical" week rather than the "last" week. This tool is a general assessment that measures stress, it is not meant to be specialized for the DDSN service population. There are many other areas of the respite assessment that address specific needs related to disabilities.

We will not be developing abbreviated service assessments for use in emergencies as this is something that rarely occurs and should be handled on a cases to case basis with a call to Central Office. Additionally we had a question about the need to reassess services. Services always must be reassessed as a person's life changes, including changes in the current service package.

South Carolina Department of Disabilities and Special Needs

Guidance for HASCI Waiver Attendant Care/Personal Assistance

This guide is designed to break down each question of the Attendant Care/Personal Assistance Assessment in a way that clearly states what each question is assessing and what the responses indicate.

Cueing is included as a component of Attendant Care/Personal Assistance Services. If the participant requires step by step direction/cueing, with the identified task, please mark the "requires cueing" to indicate the type of assistance necessary, and score the question based on the degree of cueing required.

Personal Care Tasks:

Directions: Put an X in the boxes below that correspond with the most appropriate answer. Use your professional judgement and answer as accurately as possible.

1. Bathing/Showering Task

Getting in and out of tub/shower, bathing

This question assesses the amount of support needed in order for the participant to maintain proper hygiene.

- The "0" response is for participants who are independent or only need prompts to complete their bathing.
    - Keep in mind that children under 6 may still need assistance with bathing. If a response higher than "0" is being given, the assessment should include how this support goes beyond that of individual of the same age without a disability.
- The "1" response indicates participants who have difficulty getting in and out of the bath/shower, but once they are in, they can bathe on their own.
- The "2" response indicates that the participant requires some hands on assistance. For example, the individual needs some hands on assistance washing body or hair but can wash a portion of his/her body independently.
- The "4" response indicates the participant needs complete, hands on assistance with bathing.

2. Dressing Task(s)

Requires assistance with ordinary clothing and application of braces, splints and/or support stockings

These questions assess how much assistance is needed with applying braces, splints, and/or support stockings or getting fully dressed. The use of these items, if applicable, must be clearly documented in the annual assessment.

- The "0" response indicates the participant is independent.
    - Keep in mind that children under 6 may still need assistance with dressing. If a response higher than "0" is being given the assessment should include how this support goes beyond that of individual of the same age without a disability.
- The "2" response indicates the participant needs physical assistance applying the item or clothes once in the morning and once at night (a typical number of clothing changes).

- The “4” indicates the item needs to be changed multiple times per day. Clear documentation as to why the items or clothes are being changed multiple times per day needs to be included in an assessment (annual or service assessment).

3. Feeding Tasks

Are they unable to chew and swallow without difficulty, do they need assistance in being positioned upright, do they need assistance in eating

This question assesses whether the participant needs assistance with the physical act of eating. This question is not assessing the need for meal preparation.

- The “0” response indicates the participant is capable of feeding himself/herself.
- The “1” response indicates the participants who are either partially independent with the physical task and/or at low risk for choking.
- The “2” indicates a participant who does not have a G-Tube but cannot complete the physical task of eating or is at a high risk of choking.

4. Medication Task - Medication Reminder

This question is assessing if any support is needed to ensure that the participant takes his/her medication in a safe, timely manner. Children under the age of 12 are expected to need assistance with this task.

- The “0” response indicates the participant is independent with medications or does not take medications on a regular basis.
    - Children under the age of 12 are included in this response. For a response greater than “0” information must be included in the annual assessment that clearly demonstrates how they need medical assistance that goes beyond the assistance that would be provided to a typical child of the same age.
- The “1” response indicates any assistance routinely provided such as setting out medications, providing reminders, opening bottles, etc.

5. Mobility/Ambulation/Locomotion Task

Unable to balance and bear weight reliably, Unable to ambulate

This question assesses the participant’s ability to walk or stand without hands on assistance from a caregiver. This is not assessing assistance with transferring.

- The “0” response indicates the participant can walk independently, is independently mobile with the use of a device (walker/wheelchair), or whose mobility is similar to their peers without disabilities. (If the participant is independently mobile once in the wheelchair, score zero)
- The “1” response indicates those who need some assistance navigating their environment. For example, they can navigate familiar environments such as the family home but need assistance in new settings or someone who needs assistance being pushed up ramps or hills.
- The “2” indicates the participant needs hands-on assistance to move everywhere or cannot operate their own wheelchair.

6. Meal Preparation

Are meals prepared for the participant

This question assesses the participant's ability to prepare their own meals.
The "0" indicates participants who are independent adults or children under 8.
The "1" indicates the participant requires hands on assistance with any portion of the task. For example, the participant is able to prepare cereal or assist with small portions of meal preparation however; they are unable to use the stove and/or oven to prepare a meal.
The "2" indicates all meal preparation is completed by another.
The "3" indicates the participant's food must be processed in addition to being completed by another (also includes chopping, dicing, blending, etc.).

7. Hygiene - Hair Care/Grooming Task

Styling of hair with standard hair products, to include drying, combing, and styling

8. Hygiene - Mouth Care Task

Basic Oral Hygiene and/or denture care

9. Hygiene - Shaving Task

Requires assistance with an electric or safety razor

These questions above assess the participant's ability to complete basic grooming tasks.

- The "0" indicates participants who are independent with the tasks, or the task is not needed.
- The "1" indicates any assistance provided including prompting.

10. Hygiene - Skin Care Task

Participant must have unbroken skin with no active chronic skin problems, requires preventative rather than therapeutic skin care, including the application of non-medicated, non-prescription skin products.

This question assesses how much preventative skin care is required.

- The "0 indicates the participant either does not require any skin care, is independent, or their level of independence matches their peers.
- The "1" indicates the participant requires some level of skin care once per day and is unable to complete it on their own.
- The "2" indicates participants who require some level of skin care more than once per day.
    - If this is occurring more than once per day and the reasoning needs to be documented in the annual assessment.

11. Toileting - Bowel Care
Task(s)
Requires assistance to and from the bathroom, Requires bedpan and/or commode to include pericare, Requires changing of clothing or pads.

The frequency of bowel movements for the individual is on average:

Participant requires assistance with bowel hygiene…

This 2 part question assesses the amount of bowel care needed based on how often the participant has a bowel movement and the level of assistance needed with hygiene after each bowel movement. This does not include skilled care.

Part A

- The "0" response indicates those who are independent regardless of how many bowel movement the participant has per day.
- The "1" response indicates those who are not independent and are having 1 to 4 bowel movements per day.
- The "2" response indicates those who are having four or more bowel movements per day.
    - The justification for marking this level of frequency needs to be documented in the annual assessment.

Part B

- The "0" indicates participants who are independent or whose independence matches their peers.
- The "2" indicates a participant who requires assistance with cleaning after a bowel movement.
- The "4" indicates the participant needs to be physically cleaned every time they have a bowel movement.

12. Toileting - Bowel Program _____ Requires Cueing

Requires ostomy bag and/or urinary collection devices emptied (not to include skilled care)

This question is directly asking if there is an ostomy or urinary collection needed for this participant.

- The "0" response indicates the participant who does not have these types of devices or does not need skilled care.
- The "1" response indicates the participant has an ostomy bag and does not require skilled care.

13. Toileting - Catheter Care

Requires emptying of urinary collection devices, such as catheter bags, Pericare if the client has an indwelling catheter

a)Participant requires assistance with catheter care (not to include skilled care)

b)Menses

This is a 2 part question which assesses the need for assistance with catheter care and menses.

Part 1

- The two "0" responses indicate participants who do not use a catheter and who do not need to document their urination for any purpose.
- The "1" indicates a participant who needs assistance with catheter care to include documentation.
    - If this care is being provided by an attendant it cannot be skilled care and must be clearly documented in the annual assessment.

Part 2

- The two "0" responses indicate the participant does not have menses or only needs occasional assistance with feminine hygiene products.
    - Participant's age and type of birth control needs to be taken into consideration.
- The "1" response indicates the participant needs physical assistance applying and disposing of feminine hygiene products.

14. Toileting - Bladder Care

Requires assistance to/from bathroom, requires bedpan and or commode, requires changing of clothing or pads, Includes diaper changes or perineal care associated with diaper changes

This question assesses how much physical assistance is needed with the listed activities.

- The "0" response indicates those who are independent or are at the same independence level as their peers.
- The "1" indicates the participant occasionally needs to be physically assisted to the bathroom and toilet, assisted in removing clothing, and/or needs assistance with disposing of the items, etc.
- The "2" indicates the participant predominantly needs physical assistance with any of the listed tasks.

15. Mobility - Positioning Task

As age appropriate, is unable to independently change position as needed.

This question assesses the participant's ability to change position as needed.

- The "0" indicates the participant does not need assistance with changing positions
- The "1" indicates those who have occasional issues with positioning such as those who may forget that they have remained in one positon too long.
- The "2" indicates those who have to be routinely repositioned to avoid skin break down.

16. Mobility - Transfer
Task(s)
As age appropriate requires assistance in transferring
This question assesses the participant's ability to get up from or down to a seated position or their ability to move themselves from one seated location to another such as moving from the bed to the wheelchair.

- The "0" indicates the participant requires no assistance
- The "2" indicates those who only need assistance in certain cases, such as when moving from the wheelchair to the car, or only from the bed to standing but once up are independent.
- The "4" indicates the participant needs help with transferring most of the time and in most situations.

17. Monitoring
Does the participant require monitoring of temperature or other vitals?
This question assesses the participant's need to have their vitals checked on a routine basis.

- The "0" response indicates those who do not require medical or vital monitoring.
- The "1" response indicates those who require monitoring 3 to 4 times per day
    - The need for this monitoring must be clearly stated in the annual assessment. A doctor's order for this need is recommended.
- The "2" response indicates those who require monitoring 5 or more times a day
    - The need for this monitoring must be clearly stated in the annual assessment. A doctor's order for this need is recommended.

Personal Care Modifiers (Part A)

How often does the participant's ability to express their thoughts, feelings, and needs when talking (or using their hands) affect the caregiver's (natural or paid) ability to meet their needs?
This question assesses the participant's ability to communicate with their caregiver (natural or paid).

- The "0" response indicates those who are able to communicate their wants and needs whether it is in a verbal or nonverbal form.
- The "1" indicates those who rarely have trouble communicating with their caregiver.
    - The reason for this difficulty must be clearly documented in the annual assessment in the Communication section.
- The "2" indicates those who regularly struggle to be understood by their caregiver
    - The reason for this difficulty must be clearly documented in the annual assessment in the Communication section.
- The "3" indicates those who have little to no ability to communicate with their caregiver.

How often does the participant's ability to cooperate and communicate safely affect the caregiver's ability to meet their needs?
This question assesses the participant's communication style and willingness to cooperate with the caregiver. "Communicating safely" means communicating without behaviors that might cause danger or problems to the caregiver. This is not assessing their overall ability to communicate and cooperate.

- The “0” response indicates those whose communication style does not pose a risk to themselves or others and they are willing to cooperate. This participant is not actively working against the primary caregiver when they are completing personal care tasks.
- The “1” response indicates those who occasionally are resistant to care and/or whose communication style poses a risk to themselves or others.
- The “2” response indicates those who routinely resist care and/or whose communication style poses a risk to themselves or others.
- The “3” response indicates those who consistently resist care.

How often does the participant’s ability to control their muscles when they are trying to move their body affect the caregiver's ability to meet their needs?
This question assesses the participant’s ability to control their muscles and assist with moving their body during care. This is not assessing the participant’s willingness to cooperate just their ability to move their body. This question looks at the lack of ability to move one’s own muscles with reliability and accuracy. If this is hindered by seizures and there is medication being provided, include information about the medication’s effect on the seizure activity. Seizure activity is primarily measured in the next section and this question is geared toward active control of muscles when moving.

- The “0” response indicates those who have complete control over their body.
- The “1” response indicates those who have control over the majority of their body or have control over their whole body most of the most of the time.
- The “2” response indicates those who have some capacity to control either their total body for inconsistent amounts of time or who have control over a limited area of the body.
- The “3” response indicates those who have minimal to no control over their body.

Personal Care Modifiers (Part B)

How often does the participant’s ability to breathe when doing activities affect the caregiver's ability to meet their needs?
This question assesses the participant’s ability to breathe and its impact on the caregiver’s ability to provide care. This is referring to someone who is short of breath, requiring additional time and effort to complete the task.

- The “0” response indicates those who have no concerns with breath or their breathing has no impact on the caregiver’s ability to provide care.
- The “1” response indicates those who have occasional breathing difficulties that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The “2” response indicates those whose breathing routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The “3” response indicates those whose breathing regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

How often does the participant's ability to hear what people say affect the caregiver's ability to meet their needs?
This question assesses the participant's ability to hear and its impact on the caregiver's ability to provide care. This is referring to someone who has hearing difficulties, which impact the time and effort to complete the task.

- The "0" response indicates those who have no concerns with hearing or their hearing has no impact on the caregiver's ability to provide care.
- The "1" response indicates those who have occasional hearing difficulties that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The "2" response indicates those whose hearing routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The "3" response indicates those whose hearing regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

How often does the amount of pain the participant experiences affect the caregiver's ability to meet their needs?
This question assesses the participant's pain and its impact on the caregiver's ability to provide care. The type of pain being assessed is chronic pain, pain from surgery/injury, or times the participant is in pain and this causes them to resist care. If it is due to a surgery a projected recovery date must be included. The pain and treatment plan must be clearly documented in the annual assessment.

- The "0" response indicates those who do not have any concerns with pain, whose pain is infrequent (1 to 4 times per year), or whose pain has no impact on the caregiver's ability to provide care.
- The "1" response indicates those who have pain on a monthly basis that prevents or impedes the caregiver from providing care.
- The "2" response indicates those who have pain on a weekly basis that prevents or impedes the caregiver from providing care.
- The "3" response indicates those who have pain on a daily basis that prevents or impedes the caregiver from providing care.

How often does the participant experience uncontrollable body shakes that affect the caregiver's ability to meet their needs?
This question is assessing the frequency of uncontrollable body shakes. The cause and frequency of these body shakes need to be clearly documented in the annual assessment.

- The "0" response indicates those who do not experience uncontrollable body shakes or it rarely happens
- The "1" response indicates those who have body shakes on a monthly basis that prevent or impede the caregiver from providing care.
- The "2" response indicates those who have body shakes on a weekly basis that prevent or impede the caregiver from providing care.
- The "3" response indicates those who have body shakes on a daily basis that prevent or impede the caregiver from providing care.

How often does the participant's vision affect the caregiver's ability to meet their needs?
This question assesses the participant's vision and its impact on the caregiver's ability to provide care. This is referring to someone who has vision difficulties, which impact the time and effort to complete the task.

- The "0" response indicates those who have no concerns with sight or it has no impact on the participant's ability to provide care (it is remedied with corrective lenses or is not significant enough to affect care).
- The "1" response indicates those who have occasional difficulties with their sight that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The "2" response indicates those who have difficulties with their sight and it routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The "3" response indicates those who have difficulties with their sight that regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

Personal Care Modifiers (Part B Add-On)

All of the following questions assess the ability for the participant to physically complete the task. For each question the frequency of the participant's ability to complete the task must be clearly documented in the annual assessment. The responses to these questions should not contradict the responses to previous questions about grooming, mobility, and transferring.

Are they able to recognize the need to move their body?
Are they able to keep their skin dry to prevent skin breakdown?
Are they able to move and walk around?
Are they able to move their body when they want to?
Are they able to eat without assistance?
How much assistance do they need when they change position(s)?

Home Support Tasks:

1. Cleaning

Does the participant require assistance with cleaning their room

This question assesses how much involvement the participant has with cleaning their living areas. This is not assessing for those who are capable of completing the task but do not because someone else does it for them. These participants still have the capability to complete the task.

- The "0" response indicates those who are either independent, can clean with the use of reminders, whose skills are comparable to individuals with developmentally typical personal care skills.
- The "1" response indicates those who occasionally need physical assistance with completing the task.
- The "2" response indicates those who are not capable of completing house cleaning tasks.

2. Laundry

The participant needs assistance in completing their laundry as well as putting it away when complete

This question assesses how much involvement the participant has with completing their laundry. This is not assessing for those who are capable of completing the task but do not because someone else does it for them. These participants still have the capability to complete the task.

- The "0" indicates those who are independent, only need prompts, or whose skills are comparable to individuals with developmentally typical personal care skills.
- The "1" response indicates hands on, physical assistance with any portion of the task.
- The "2" response indicates those who have no ability to complete their own laundry.

3. Shopping/Errands

Does the participant require assistance with shopping or running errands

This question assesses how much involvement the participant has with shopping or if their shopping creates a significant increase in the time spent shopping.

- The "0" response indicates those who can either complete their own shopping, can go with the caregiver and assist with shopping, or the shopping is completed at the same time as other shopping done for the family, or their shopping skill is comparable to individuals with developmentally typical personal care skills.
- The "1" indicates those who need assistance occasionally or who's shopping has a significant impact on the amount of time needed to complete the errand.
- The "2" indicates those who cannot complete any shopping and whose shopping requires extra trips, stops, etc. on a regular basis causing a significant increase to the amount of time needed to complete the shopping.

South Carolina Department of Disabilities and Special Needs

Guidance for ID/RD and CS Waiver Personal Care/Attendant Care Assessment

This guide is designed to break down each question of the Personal Care assessment in a way that clearly states what each question is assessing and what the responses indicate.

Personal Care Tasks:

Directions: Put an X in the boxes below that correspond with the most appropriate answer. Use your professional judgement and answer as accurately as possible.

1. Bathing/Showering Task

Getting in and out of tub/shower, bathing

This question assesses the amount of support needed in order for the participant to maintain proper hygiene.

- The "0" response is for participants who are independent or only need prompts to complete their bathing.
    - Keep in mind that children under 6 may still need assistance with bathing. If a response higher than "0" is being given, the assessment should include how this support goes beyond that of individual of the same age without a disability.
- The "1" response indicates participants who have difficulty getting in and out of the bath/shower but once they are in they can bathe on their own.
- The "2" response indicates that the participant requires some hands on assistance. For example, the individual needs some hands on assistance washing body or hair.
- The "3" response indicates participants who need complete, hands on assistance with bathing.

2. Dressing Task(s)

Requires assistance with ordinary clothing and application of braces, splints and/or support stockings

These questions assess how much assistance is needed with applying braces, splints, and/or support stocking or getting fully dressed. The use of these items, if applicable, must be clearly documented in the annual assessment.

- The "0" response is for participants who are independent or only need prompts to apply the item or clothes.
    - Keep in mind that children under 6 may still need assistance with dressing. If a response higher than "0" is being given the assessment should include how this support goes beyond that of individual of the same age without a disability.
- The "2" response indicates participants who need physical assistance applying the item or clothes once in the morning and once at night (a typical number of clothing changes).
- The "4" indicates the item needs to be changed multiple times per day. Clear documentation as to why the items or clothes are being changed multiple times per day needs to be included in an assessment (annual or service assessment).

3. Feeding Tasks

Are they unable to chew and swallow without difficulty, do they need assistance in being positioned upright, do they need assistance in eating

This question assesses whether the participant needs assistance with the physical act of eating. This question is not assessing the need for meal preparation.

- The "0" response indicates participants who are capable of feeding themselves.
- The "1" response indicates participants who are either partially independent with the physical task and/or at a low risk of choking.
- The "2" indicates a participant who does not have a G-Tube but cannot complete the physical task of eating or is at a high risk of choking.

4. Medication Task - Medication Reminder

This question is assessing if any support is needed to ensure that the participant takes their medication in a safe, timely manner. For children under the age of 12, they are expected to need assistance with this task.

- The "0" response indicates the participant is independent with their medications or does not take medications on a regular basis.
    - Children under the age of 12 are included in this response. For a response greater than "0" information must be included in the annual assessment that clearly demonstrates how they need medical assistance that goes beyond the assistance that would be provided to a typical child of the same age.
- The "1" response indicates any assistance provided such as setting out medications, providing reminders, opening bottles, etc.

5. Mobility/Ambulation/Locomotion Task

Unable to balance and bear weight reliably, Unable to ambulate

This question assesses the participant's ability to walk or stand without hands on assistance from a caregiver. This is not assessing assistance with transferring.

- The "0" response indicates the participant can walk independently, is independently mobile with the use of a device (walker/wheelchair), or whose mobility is similar to their peers without disabilities.
- The "1" response indicates those who need some assistance navigating their environment. For example, they can navigate familiar environments such as the family home but need assistance in new settings or someone who needs assistance being pushed up ramps or hills.
- The "2" indicates participants who need hands-on assistance to move everywhere or cannot operate their own wheelchair.

6. Meal Preparation

Are meals prepared for the individual

This question assesses the participant's ability to prepare their own meals.
The "0" indicates participants who are independent adults or children under 8.
The "1" indicates the participant requires hands on physical assistance with any portion of the task.
The "2" indicates all meal preparation is completed by another.
The "3" indicates the participant's food must be processed in addition to be completed by another (includes chopping, dicing, blending, etc)

7. Hygiene - Hair Care/Grooming Task

Styling of hair with standard hair products, to include drying, combing, and styling

8. Hygiene - Mouth Care Task

Basic Oral Hygiene and/or denture care

9. Hygiene - Shaving Task

Requires assistance with an electric or safety razor

These questions assess the participant's ability to complete basic grooming tasks.

- The "0" indicates participants who are independent with the tasks or the task is not needed.
- The "1" indicates any assistance provided including prompting.

10. Hygiene - Skin Care Task

Individual must have unbroken skin with no active chronic skin problems, requires preventative rather than therapeutic skin care, including the application of non-medicated, non-prescription skin products.

This question assesses how much preventative skin care is required.

- The "0 indicates participants who either do not require any skin care, are independent, or their level of independence matches their peers.
- The "1" indicates participants who require some level of skin care once per day and is unable to complete it on their own.
- The "2" indicates participants who require some level of skin care more than once per day.

If this is occurring more than once per day and the reasoning needs to be documented in the annual assessment.

11. Toileting - Bowel Care Task(s)

Requires assistance to and from the bathroom, Requires bedpan and/or commode to include pericare, Requires changing of clothing or pads.

The frequency of bowel movements for the individual is on average:

Individual requires assistance with bowel hygiene…

This 2 part question assesses the amount of bowel care needed based on how often the participant has a bowel movement and the level of assistance needed with hygiene after each bowel movement.

Part a)

- The "0" response indicates those who are independent regardless how many bowel movement the participant has per day.
- The "1" response indicates those who are not independent and are having 1 to 4 bowel movements per day.
- The "2" response indicates those who are having four or more bowel movements per day.
    - The justification for marking this level of frequency needs to be documented in the annual assessment.

Part b)

- The "0" indicates participants who are independent or whose independence matches their peers.
- The "2" indicates a participant who occasionally needs physical assistance with cleaning after a bowel movement.
- The "4" indicates a participant who needs to be physically cleaned every time they have a bowel movement.

12. Toileting - Bowel Program

Requires ostomy bag and/or urinary collection devices emptied

This question is directly asking if there is an ostomy or urinary collection needed for this participant.

- The "0" response indicates a participant who does not have these type of devices or does not need skilled care.
- The "1" response indicates a participant who does have an ostomy bag and does not require skilled care.

13. Toileting - Catheter Care

Requires emptying of urinary collection devices, such as catheter bags, Pericare if the client has an indwelling catheter

Individual requires assistance with catheter care (not to include skilled care)

Menses

This is a 2 part question which assesses the need for assistance with catheter care and menses.

Part 1

- The two "0" responses indicates participants who do not use a catheter and who do not need to document their urination for any purpose.
- The "1" indicates a participant who needs assistance with catheter care to include documentation.
    - If this care is being provided by a PCA it cannot be skilled care and must be clearly documented in the annual assessment.

Part 2

- The two "0" responses indicate the participant does not have menses or only needs occasional assistance with feminine hygiene products.
    - Participant's age and type of birth control needs to be taken into consideration.
- The "1" response indicates someone who needs physical assistance applying and disposing feminine hygiene products.

14. Toileting - Bladder Care Tasks

Requires assistance to/from bathroom, requires bedpan and or commode, requires changing of clothing or pads, Includes diaper changes or perineal care associated with diaper changes

This question assesses how much physical assistance is needed with the listed activities.

- The "0" response indicates those who are independent, only need reminders or prompting, or are at the same independence level as their peers.
- The "1" indicates someone who occasionally needs to be physically assisted to the bathroom and toilet, assisted in removing clothing, and/or needs assistance with disposing of the items, etc.
- The "2" indicates someone who predominantly needs physical assistance with any of the listed tasks.

15. Mobility - Positioning Task

As age appropriate, is unable to independently change position as needed.

This question assesses the participant's ability to notify their caregiver when they need to be repositioned. This notification can be verbal or non-verbal.

- The "0" indicates the participant does not need assistance with changing positions
- The "1" indicates those who have occasional issues with positioning such as those who will forget that they have remained in one positon too long.
- The "2" indicates those who have to be routinely repositioned to avoid skin break down.

16. Mobility - Transfer Task(s)

As age appropriate requires assistance in transferring

This question assesses the participant's ability to get up from or down to a seated position or their ability to move themselves from one seated location to another such as moving from the bed to the wheelchair.

- The "0" indicates those who require no assistance
- The "2" indicates those who only need assistance in certain cases such as moving from the wheelchair to the car, or only from the bed to standing but once up are independent.
- The "4" indicates individuals who need help with transferring most of the time and in most situations.

17. Monitoring

Does the individual require monitoring of temperature or other vitals?

This question assesses the participant's need to have their vitals checked on a routine basis.

- The "0" response indicates those who do not require medical or vital monitoring.
- "The "1" response indicates those who require monitoring 3 to 4 times per day
    - The need for this monitoring must be clearly stated in the annual assessment. A doctors order for this need is recommended
- The "2" response indicates those who require monitoring 5 or more times a day
    - The need for this monitoring must be clearly stated in the annual assessment. A doctors order for this need is recommended

Personal Care Modifiers (Part A)

How often does the individual's ability to express their thoughts, feelings, and needs when talking (or using their hands) affect the caregiver's (natural or paid) ability to meet their needs?
This question assesses the participant's ability to communicate with their Caregiver (natural or paid).

- The "0" response indicates those who are able to communicate their wants and needs whether it is in a verbal or nonverbal form.
- The "1" indicates those who rarely have trouble communicating with their caregiver.
    - The reason for this difficulty must be clearly documented in the annual assessment in the Communication section.
- The "2" indicates those who regularly struggle to be understood by their caregiver
    - The reason for this difficulty must be clearly documented in the annual assessment in the Communication section.
- The "3" indicates those who have little to no ability to communicate with their caregiver.

How often does the individual's ability to cooperate and communicate safely affect the caregiver's ability to meet their needs?
This question assesses the participant's communication style and willingness to cooperate with the caregiver. "Communicating safely" means communicating without behaviors that might cause danger or problems to the caregiver. This is not assessing their overall ability to communicate and cooperate.

- The "0" response indicates those whose communication style does not pose a risk to themselves or others and they are willing to cooperate. This participant is not actively working against the primary caregiver when they are completing personal care tasks.
- The "1" response indicates those who occasionally are resistant to care and/or whose communication style poses a risk to themselves or others.
- The "2" response indicates those who routinely resist care and/or whose communication style poses a risk to themselves or others.
- The "3" response indicates those who are consistently resisting care.

How often does the individual's ability to control their muscles when they are trying to move their body affect the caregiver's ability to meet their needs?
This question assesses the participant's ability to control their muscles and assist with moving their body during care. This is not assessing the participant's willingness to cooperate just their ability to move their body. This question looks at the lack of ability to move one's own muscles with reliability and accuracy. If this is being caused by seizures and there is medication being provided, include information about the medication's effect on the seizure activity. Seizure activity is primarily measured in the next section and this question is geared toward active control of muscles when moving.

- The "0" response indicates those who have complete control over their body.
- The "1" response indicates those who have control over the majority of their body or have control over their whole body most of the most of the time.
- The "2" response indicates those who have some capacity to control either their total body for inconsistent amounts of time or who have control over a limited area of the body.
- The "3" response indicates those who have minimal to no control over their body.

Personal Care Modifiers (Part B)

How often does the individual's ability to breathe when doing activities affect the caregiver's ability to meet their needs?
This question assesses the participant's ability to breath and its impact on the caregiver's ability to provide care. This is referring to someone who is short of breath, requiring additional time and effort to complete the task.

- The "0" response indicates those who have no concerns with breath or their breathing has no impact on the participant's ability to provide care.
- The "1" response indicates those who have occasional breathing difficulties that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The "2" response indicates those whose breathing routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The "3" response indicates those whose breathing regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

How often does their ability to hear what people say affect the caregiver's ability to meet their needs?
This question assesses the participant's ability to hear and its impact on the caregiver's ability to provide care. This question is referring to someone who has hearing difficulties which impact the time and effort required to complete the task.

- The "0" response indicates those who have no concerns with hearing or their hearing has no impact on the caregiver's ability to provide care.
- The "1" response indicates those who have occasional hearing difficulties that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The "2" response indicates those whose hearing routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The "3" response indicates those whose hearing regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

How often does the amount of pain they experience affect the caregiver's ability to meet their needs?
This question assesses the participant's pain and its impact on the caregiver's ability to provide care. The type of pain being assessed is chronic pain, pain from surgery/injury, or times the participant is in pain and this causes them to resist care. If it is due to a surgery a projected recovery date needs to be included. The pain and treatment plan must be clearly documented in the annual assessment.

- The "0" response indicates those who do not have any concerns with pain, whose pain is infrequent (1 to 4 times per year), or whose pain has no impact on the caregiver's ability to provide care.
- The "1" response indicates those who have pain on a monthly basis that prevents or impedes the caregiver from providing care.
- The "2" response indicates those who have pain on a weekly basis that prevents or impedes the caregiver from providing care.
- The "3" response indicates those who have pain on a daily basis that prevents or impedes the caregiver from providing care.

How often do they experience uncontrollable body shakes that affect the caregiver's ability to meet their needs?
This question is assessing the frequency of uncontrollable body shakes. The cause and frequency of these body shakes need to be clearly documented in the annual assessment.

- The "0" response indicates those who do not experience uncontrollable body shakes or it rarely happens
- The "1" response indicates those who have body shakes on a monthly basis that prevent or impede the caregiver from providing care.
- The "2" response indicates those who have body shakes on a weekly basis that prevent or impede the caregiver from providing care.
- The "3" response indicates those who have body shakes on a daily basis that prevent or impede the caregiver from providing care.

How often does their ability to see things affect the caregiver's ability to meet their needs?
This question assesses the participant's vision and its impact on the caregiver's ability to provide care. This question is referring to someone who has vision difficulties which impact the time and effort required to complete the task.

- The "0" response indicates those who have no concerns with sight or it has no impact on the participant's ability to provide care (it is remedied with corrective lenses or is not significant enough to affect care).
- The "1" response indicates those who have occasional difficulties with their sight that would cause the caregiver to have to stop or slow down when performing personal care tasks.
- The "2" response indicates those who have difficulties with their sight and it routinely prevents the caregiver from providing care or significantly increases the time needed to complete the task.
- The "3" response indicates those who have difficulties with their sight that regularly prevents the caregiver from providing care or significantly increases the time needed to complete the task.

Personal Care Modifiers (Part B Add-On)

All of the following questions assess the ability for the participant to physically complete the task. For each question the frequency of the participant's ability to complete the task must be clearly documented in the annual assessment. The responses to these questions should not contradict the responses to previous questions about grooming, mobility, and transferring.

Are they able to recognize the need to move their body?
Are they able to keep their skin dry in order to prevent skin breakdown?
Are they able to move and walk around?
Are they able to move their body when they want to?
Are they able to eat without assistance?
How much assistance do they need when they change position(s)?

Home Support Tasks:

1. Cleaning

Does the Individual require assistance with cleaning their room

This question assesses how much involvement the participant has with cleaning their living areas. This is not assessing for those who are capable of completing the task but do not because someone else does it for them. These individuals still have the capability to complete the task.

- The "0" response indicates those who are either independent, can clean with the use of reminders, whose skills are comparable to individuals with developmentally typical personal care skills.
- The "1" response indicates those who occasionally need physical assistance with completing the task.
- The "2" response indicates those who are not capable of completing house cleaning tasks.

2. Laundry

The individual needs assistance in completing their laundry as well as putting it away when complete

This question assesses how much involvement the participant has with completing their laundry. This is not assessing for those who are capable of completing the task but do not because someone else does it for them. These individuals still have the capability to complete the task.

- The "0" indicates those who are independent, only needs prompts, or whose skills are comparable to individuals with developmentally typical personal care skills.
- The "1" response indicates that hands on, physical assistance is needed with any portion of the task.
- The "2" response indicates those who have no ability to complete their own laundry.

3. Shopping/Errands

Does the Individual require assistance with shopping or running errands

This question assesses how much involvement the participant has with shopping or if their shopping creates a significant increase in the time spent shopping.

- The “0” response indicates those who can either complete their own shopping, can go with the caregiver and assist with shopping, or the shopping is completed at the same time as other shopping done for the family, or their shopping skill is comparable to individuals with developmentally typical personal care skills.
- The “1” indicates those who need assistance occasionally or who’s shopping has a significant impact on the amount of time needed to complete the errand.
- The “2” indicates those who cannot complete any shopping and whose shopping requires extra trips, stops, etc. on a regular basis causing a significant increase to the amount of time needed to complete the shopping.

South Carolina Department of Disabilities and Special Needs
Attendant Care/Personal Assistance Assessment
HASCI WAIVER

Consumer Name: _____ Gender: _____

DOB: _____

DSN Board/Provider: _____ CM/EI: _____

Consumer's Primary Diagnosis: _____
If Other: _____

Additional Diagnoses (List all that apply):

_____

Equipment currently used by/for this consumer:

_____

Personal Care Tasks:

Directions: Put an X in the boxes below that correspond with the most appropriate answer. Use your professional judgement and answer as accurately as possible.

1. Bathing/Showering Task _____ Requires Cueing

Getting in and out of tub/shower

	0	None, is independent, can verbally cued, or is age appropriate
	1	Getting in and out of the tub/shower, independent in bathing/rinsing
	2	Hands on, physical assistance needed with bathing/rinsing
	3	Completed by another

2. Dressing Task(s) _____ Requires Cueing

Requires assistance with ordinary clothing and application of braces, splints and/or support stockings

a) Requires dressing assistance:

	0	No assistance needed or age appropriate
	2	Daily (one change of clothing in the morning and one at night)
	4	Greater than once per day

b) Braces, Splints or Stockings applied…

	0	N/A or None, is independent, or is age appropriate
	1	Daily
	2	Greater than once per day

3. Feeding Tasks _____ Requires Cueing

Are they unable to chew and swallow without difficulty, do they need assistance in being positioned upright, do they need assistance in eating

	0	None, is independent with chewing and swallowing without difficulty, does not eat by mouth or is age appropriate
	1	Hands on, physical assistance needed
	2	Completed by another

Page Total
0

4. Medication Task - Medication Reminder _____ Requires Cueing

Includes: Asking if medications were taken, verbal prompting, cueing, providing assistance opening the marked medication container

	0	None or Does not take medications regularly
	1	Needs assistance or any kind

5. Mobility/Ambulation/Locomotion Task

Unable to balance and bear weight reliably, Unable to ambulate

	0	N/A or None, is independent (with device), or is age appropriate
	1	Must have personal assistance
	2	Must be physically transferred

6. Meal Preparation _____ Requires Cueing

Are meals prepared for the participant

	0	Is independent or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another
	3	Requires processing in addition to being completed by another

7. Hygiene - Hair Care/Grooming Task _____ Requires Cueing

Styling of hair with standard hair products, to include drying, combing, and styling

	0	Independent and/or age appropriate
	1	Any assistance provided

8. Hygiene - Mouth Care Task _____ Requires Cueing

Basic Oral Hygiene and/or denture care

	0	Independent and/or age appropriate
	1	Any assistance provided

9. Hygiene - Shaving Task _____ Requires Cueing

Requires assistance with an electric or safety razor

	0	Independent and/or not needed
	1	Any assistance provided

10. Hygiene - Skin Care Task _____ Requires Cueing

Participant must have unbroken skin with no active chronic skin problems, requires preventative rather than therapeutic skin care, including the application of non-medicated, non-prescription skin products

	0	No assistance, is independent or age appropriate.
	1	Daily
	2	Greater than once per day

11. Toileting - Bowel Care Task(s) _____ Requires Cueing

Requires assistance to and from the bathroom, Requires bedpan and/or commode to include pericare, Requires changing of clothing or pads (not to include skilled care)

a) The frequency of bowel movements for the individual is on average:

	0	Independent in Toileting
	1	1-3 times a day
	2	4 or more times a day

Page Total
0

b) Participant requires assistance with bowel hygiene…

	0	None, is independent, or is age appropriate
	2	Hands on, physical assistance needed with any portion of the task
	4	Completed by another

12. Toileting - Bowel Program _____ Requires Cueing

Requires ostomy bag and/or urinary collection devices emptied (not to include skilled care)

	0	Does not have an ostomy or utilizes paid skilled care
	1	Has an ostomy and does not require skilled care

*Skilled care includes recording of outputs or digital stimulation, suppositories or enemas.

13. Toileting - Catheter Care _____ Requires Cueing

Requires emptying of urinary collection devices, such as catheter bags, Pericare if the client has an indwelling catheter

a) Participant requires assistance with catheter care (not to include skilled care)

	0	No Catheter or Independent
	0	Without recording or reporting output and/or breaking the tubing seal
	1	Hands on, physical assistance needed with any portion of the task

b) Menses

	0	Is male and/or does not have menses
	0	Hands on, physical assistance needed with any portion of the task
	1	Completed by another

14. Toileting - Bladder Care Tasks _____ Requires Cueing

Requires assistance to/from bathroom, requires bedpan and or commode, requires changing of clothing or pads, Includes diaper changes or perineal care associated with diaper changes

	0	Independent, requires only prompting, or age appropriate
	2	Hands on, physical assistance needed with any portion of the task
	4	Completed by another

15. Mobility - Positioning Task _____ Requires Cueing

As age appropriate, is unable to change position as needed

	0	Independent and/or age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

16. Mobility - Transfer Task(s) _____ Requires Cueing

As age appropriate requires assistance in transferring

	0	Independent
	2	Hands on, physical assistance needed with any portion of the task
	4	Completed by another

17. Monitoring _____ Requires Cueing

Does the participant require monitoring of temperature or other vitals?

	0	None, or less than twice daily
	1	3-4 times daily
	2	5 or more times daily

0 Personal Care Tasks Total (from this and previous pages)

Page Total
0

Personal Care Modifiers (Part A)

Directions: Put an X in the boxes below that correspond with the most appropriate answer.

A-1) How often does the participant's ability to express their thoughts, feelings, and needs when talking (or using their hands) affect the caregiver's (natural or paid) ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

A-2) How often does the participant's ability to cooperate and communicate safely affect the caregivers ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

A-3) How often does the participant's ability to control their muscles when they are trying to move their body affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

Part A Total: 0

Personal Care Modifiers (Part B)

B-1) How often does the participant's ability to breathe when doing activities affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-2) How often does the participant's ability to hear what people say affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-3) How often does the amount of pain the participant experience affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-4) How often does the participant experience uncontrollable body shakes that affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-5) How often does the participant's vision affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

Part B Total: **0**

Personal Care Modifiers (Part B Add-on)

B-6) Are they able to recognize the need to move their body?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-7) Are they able their skin dry to prevent skin breakdown?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-8) Are they able to move and walk around?

	1	Able to walk around whenever they want to
	2	Some ability (walk occasionally but spend most time in bed/chair)
	3	Limited ability (mostly in a chair with help)
	4	Unable (always in bed)

B-9) Are they able to move their body when they want to?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-10) Are they able to eat without assistance?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-11) How much assistance do they need when they change position(s)?

	1	Never need assistance
	2	Usually need assistance
	3	Total assistance

<9	0
10-12	1
13-14	2
15-18	3
19-23	4

Part B Add-On Total: **0** this score Adds 0 to the Part B Modifier (see table)

Home Support Tasks:

Directions: Indicate (using an X) the responses to the questions below. Keep in mind all Home Support Tasks are to support the participant only and not other family members.

1. Cleaning _____ Requires Cueing

Does the participant require assistance with cleaning their room

	0	None, is independent, or is age appropriate
	0	Individual is immobile, does not leave their bed and/or transfers directly to another room
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

2. Laundry _____ Requires Cueing

The participant needs assistance in completing their laundry as well as putting it away when complete

	0	N/A or None, is independent, or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

3. Shopping/Errands _____ Requires Cueing

Does the participant require assistance with shopping or running errands

	0	None, is independent, completed by family, or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

0 Home Support Tasks Total

Totals Page

Section Totals:

0	Personal Care Tasks Total Score
0	Modifier A Total Score
0	Modifier B Total Score (with Add-On)
0	Home Support Tasks Total Score

*Use scores above in charts on this page.

Home Support Modifier

Score	Recommended Time	
1-3	0.5	Hours
4+	1	Hour

Total Score in Home Support: 0

Recommended time: 0 per day

Personal Care Tasks:

Score	Recommended Time		
1-6	Up to	1	Hour
7-12	Up to	2	Hours
13-18	Up to	3	Hours
19-25	Up to	4	Hours
26-32	Up to	5	Hours
33+	Up to	6	Hours

Total Score in Personal Care Tasks: 0

Recommended time: 0 Hours Per day

Personal Care Modifiers:

Modifier A

Score	Recommended Time	
1-4	0.5	Hours
5-8	1	Hour
9+	1.5	Hours

Total Score in Modifier A: 0

Recommended time: 0 per day

Modifier B

Score	Recommended Time	
1-8	0.5	Hours
9+	1	Hour

Total Score in Modifier B: 0

Recommended time: 0 per day

Total Recommended Time (Hours per day)

0 Hours per day

*To justify additional hours see next page

Additional Information:

Directions: If there is additional information that could be useful in accurately justifying additional hours or that is necessary to get an accurate assessment please enter it below.

Number of Units Requested: _____ per _____

Name/Title of Individual Completing Assessment: _____

Date Completed: _____

South Carolina Department of Disabilities and Special Needs
Personal Care/Attendant Care Assessment
ID/RD and CS Waiver

Consumer Name: _____ Gender: _____

DOB: _____

DSN Board/Provider: _____ CM/EI: _____

Consumer's Primary Diagnosis: _____
If Other: _____

Additional Diagnoses (List all that apply):

_____

Equipment currently used by/for this individual:

_____

Personal Care Tasks:

Directions: Put an X in the boxes below that correspond with the most appropriate answer. Use your professional judgement and answer as accurately as possible.

1. Bathing/Showering Task

Getting in and out of tub/shower, bathing

	0	None, is independent, can verbally cued, or is age appropriate
	1	Getting in and out of the tub/shower, independent in bathing/rinsing
	2	Hands on, physical assistance needed with bathing/rinsing
	3	Completed by another

2. Dressing Task(s)

Requires assistance with ordinary clothing and application of braces, splints and/or support stockings

Requires dressing assistance:

	0	No assistance needed or age appropriate
	2	Daily (one change of clothing in the morning and one at night)
	4	Greater than once per day

Braces, Splints or Stockings applied…

	0	N/A or None, is independent, can verbally cued, or is age appropriate
	1	Daily
	2	Greater than once per day

3. Feeding Tasks

Are they unable to chew and swallow without difficulty, do they need assistance in being positioned upright, do they need assistance in eating

	0	None, is independent with chewing and swallowing without difficulty, does not eat by mouth or is age appropriate
	1	Hands on, physical assistance needed
	2	Completed by another

Page Total _____

4. Medication Task - Medication Reminder

Includes: Asking if medications were taken, verbal prompting, cueing, providing assistance opening the marked medication container.

	0	None or Does not take medications regularly
	1	Needs assistance or any kind

5. Mobility/Ambulation/Locomotion Task

Unable to balance and bear weight reliably, Unable to ambulate

	0	N/A or None, is independent (with device), or is age appropriate
	1	Must have personal assistance
	2	Must be physically transferred

6. Meal Preparation

Are meals prepared for the individual…

	0	Is independent or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another
	3	Requires processing in addition to being completed by another

7. Hygiene - Hair Care/Grooming Task

Styling of hair with standard hair products, to include drying, combing, and styling…

	0	Independent and/or age appropriate
	1	Any assistance provided

8. Hygiene - Mouth Care Task

Basic Oral Hygiene and/or denture care

	0	Independent and/or age appropriate
	1	Any assistance provided

9. Hygiene - Shaving Task

Requires assistance with an electric or safety razor

	0	Independent and/or not needed
	1	Any assistance provided

10. Hygiene - Skin Care Task

Individual must have unbroken skin with no active chronic skin problems, requires preventative rather than therapeutic skin care, including the application of non-medicated, non-prescription skin products.

	0	No assistance, is independent or age appropriate.
	1	Daily
	2	Greater than once per day

11. Toileting - Bowel Care Task(s)

Requires assistance to and from the bathroom, Requires bedpan and/or commode to include pericare, Requires changing of clothing or pads (not to include skilled care)

The frequency of bowel movements for the individual is on average:

	0	Independent in Toileting
	1	1-4 times a day
	2	5 or more times a day

Page Total

Individual requires assistance with bowel hygiene…

	0	None, is independent, or is age appropriate
	2	Hands on, physical assistance needed with any portion of the task
	4	Completed by another

12. Toileting - Bowel Program

Requires ostomy bag and/or urinary collection devices emptied

	0	Does not have an ostomy or utilizes paid skilled care
	1	Has an ostomy and does not require skilled care

*Skilled care includes recording of outputs or digital stimulation, suppositories or enemas,

13. Toileting - Catheter Care

Requires emptying of urinary collection devices, such as catheter bags, Pericare if the client has an indwelling catheter

Individual requires assistance with catheter care (not to include skilled care)

	0	No Catheter or Independent
	0	Without recording or reporting output and/or breaking the tubing seal
	1	Hands on, physical assistance needed with any portion of the task

Menses

	0	Is male and/or does not have menses
	0	Hands on, physical assistance needed with any portion of the task
	1	Completed by another

14. Toileting - Bladder Care Tasks

Requires assistance to/from bathroom, requires bedpan and or commode, requires changing of clothing or pads, Includes diaper changes or perineal care associated with diaper changes

	0	Independent, requires only prompting, or age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

15. Mobility - Positioning Task

As age appropriate, is unable to change positions as needed.

	0	Independent and/or age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

16. Mobility - Transfer Task(s)

As age appropriate requires assistance in transferring

	0	Independent
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

17. Monitoring

Does the individual require monitoring of temperature or other vitals?

	0	None, or less than twice daily
	1	3-4 times daily
	2	5 or more times daily

0 Personal Care Tasks Total (from this and previous pages)

Page Total _____

Personal Care Modifiers (Part A)

Directions: Put an X in the boxes below that correspond with the most appropriate answer.

How often does the individual's ability to express their thoughts, feelings, and needs when talking (or using their hands) affect the caregiver's (natural or paid) ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

How often does the individual's ability to cooperate and communicate safely affect the caregivers ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

How often does the individual's ability to control their muscles when they are trying to move their body affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

Part A Total: 0

Personal Care Modifiers (Part B)

B-1) How often does the participant's ability to breathe when doing activities affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-2) How often does the participant's ability to hear what people say affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-3) How often does the amount of pain the participant experience affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-4) How often does the participant experience uncontrollable body shakes that affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

B-5) How often does the participant's vision affect the caregiver's ability to meet their needs?

	0	No Effect
	1	No more than on a monthly basis
	2	On a weekly basis
	3	On a daily basis

Part B Total: **0**

Personal Care Modifiers (Part B Add-on)

B-6) Are they able to recognize the need to move their body?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-7) Are they able their skin dry to prevent skin breakdown?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-8) Are they able to move and walk around?

	1	Able to walk around whenever they want to
	2	Some ability (walk occasionally but spend most time in bed/chair)
	3	Limited ability (mostly in a chair with help)
	4	Unable (always in bed)

B-9) Are they able to move their body when they want to?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-10) Are they able to eat without assistance?

	1	Always able (all the time)
	2	Some ability, more than half of the time
	3	Limited ability
	4	Unable

B-11) How much assistance do they need when they change position(s)?

	1	Never need assistance
	2	Usually need assistance
	3	Total assistance

<9	0
10-12	1
13-14	2
15-18	3
19-23	4

Part B Add-On Total: **0** this score Adds 0 to the Part B Modifier (see table)

Home Support Tasks:

Directions: Indicate (using an X) the responses to the questions below. Keep in mind all Home Support Tasks are to support the individual only and not other family members.

1. Cleaning

Does the Individual require assistance with cleaning their room

	0	None, is independent, or is age appropriate
	0	Individual is immobile, does not leave their bed and/or transfers directly to another room
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

2. Laundry

The individual needs assistance in completing their laundry as well as putting it away when complete

	0	N/A or None, is independent, or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

3. Shopping/Errands

Does the Individual require assistance with shopping or running errands

	0	None, is independent, completed by family, can verbally cued, or is age appropriate
	1	Hands on, physical assistance needed with any portion of the task
	2	Completed by another

0 Home Support Tasks Total

Totals Page

Section Totals:

0	Personal Care Tasks Total score
0	Modifier A Total score
0	Modifier B Total Score (with Add-On)
0	Home Support Tasks Total score

*Use scores above in charts on this page.

Home Support Modifier

Score	Recommended Time	
1-3	0.5	Hours
4+	1	Hour

Total score in Home Support: 0

Recommended time: 0 per day

Personal Care Tasks:

Score	Recommended Time		
1-6	Up to	1	Hour
7-12	Up to	1.5	Hours
13-18	Up to	2	Hours
19-25	Up to	2.5	Hours
26-32	Up to	3	Hours
33+	Up to	3.5	Hours

Total score in Personal Care Tasks: 0

Recommended time: 0 Hours Per day

Personal Care Modifiers:

Modifier A

Score	Recommended Time	
1-4	0	Hours
5-8	1	Hour
9+	1.5	Hours

Total score in Modifier A: 0

Recommended time: 0 per day

Modifier B

Score	Recommended Time	
1-8	0.5	Hours
9+	1	Hour

Total score in Modifier B: 0

Recommended time: 0 per day

Total Recommended Time (Hours per day)

0 Hours per day

*To justify additional hours see next page

Additional Information:

Directions: If there is additional information that could be useful in accurately justifying additional hours or that is necessary to get an accurate assessment please enter it below.

Requested Amount of **HOURS** per week (can use decimals): _____ = _____ units

Name/Title of Individual Completing Assessment: _____

Date Completed: _____

South Carolina Department of Disabilities and Special Needs
Guidance for Respite Assessment for ID/RD, CS, and HASCI
Waivers November 2018

This Respite Assessment should be completed by the Case Manager with input from the Waiver Participant, Family/Caregiver, and other service providers.

This guide is designed to break down each question of the Respite assessment in a way that clearly states what each question is assessing and what the responses indicate.

Part 1: Amount of Supervision Necessary:

Directions: to determine the level of supervision needed for the consumer find the column with his/her age and the row that on average most closely matches the amount of supervision necessary during awake hours

What level of monitoring does the client typically require during awake hours?

	Child 0-4	Child 5-11	Child 12-17	Adult 18+
Can be left unattended for extended periods of time			0	0
Can be left unattended for several hours at a time (2-4 hours) to engage in independent activities, but needs access to a support person daily for guidance or assistance			1	1
Can be left unattended for short periods of time (1-2 hours), provided that the environment is strictly structured and that a support person can respond quickly in an emergency situation			2	2
Can be left unattended for very short periods of time (while caregiver steps to a neighbors or checks the mail) but no longer than a 30 minutes.		2	3	3
Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours.	1	3	4	4
Cannot be left unattended. Requires a support person within the room or within earshot of the client's location at all times during awake hours.	3	5	5	5

After entering the appropriate supervision level, the case manager must clearly justify the selected supervision level in the box provided.

For any of the supervision levels, when explaining the justification behind the supervision level, provide clear, concrete examples of behavioral or medical issues that require supervision. If medication is being provided to address a behavior or medical condition, provide information about the impact of the medication on the behavior or condition. For juveniles, clearly state how the amount of supervision required goes beyond that of their typically developing peers. Simply stating the participant's diagnosis does not constitute justification. The level of supervision that caregivers provide is a contributing factor when selecting a supervision level.

Can be left unattended for extended periods of time: Indicates those who need no supervision and would not require respite services

Can be left unattended for several hours at a time (2-4 hours) to engage in independent activities, but needs access to a support person daily for guidance or assistance: This participant can be left alone for long periods of time but needs someone to check in on them occasionally throughout the day.

Can be left unattended for short periods of time (1-2 hours), provided that the environment is strictly structured and that a support person can respond quickly in an emergency situation: This participant cannot be left unattended for more than a couple of hours at a time and would need a structured

environment. For example: The participant could be left at home alone with a movie playing or a clearly defined task to undertake.

Can be left unattended for very short periods of time (while caregiver steps to a neighbor's or checks the mail) but no longer than 30 minutes: This indicates participants who can be left alone for short periods of time within the home. The participant can be left alone in their room for somewhere between 15 to 30 minutes without the caregiver checking on them.

Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours: This individual cannot be left unattended for any reason and requires someone on the property during the time they are awake. This individual would need someone to visually check on them every 10 -15 minutes.

Cannot be left unattended. Requires a support person within the room or within earshot of the participant's location at all times during awake hours: This participant would need constant direct supervision. This participant would need a caregiver within close proximity (same room or just outside the room) at all times. This participant requires intense supervision due to physical and/or behavioral issues.

Supervision Modifier:

Is the caregiver prevented from going on public outings or running errands due to the amount of care required by the participant (as age appropriate)?	_____ If Yes, add one point to the Supervision Score (max 5)

This section allows for an adjustment to the Supervision score if a caregiver is prevented from going on public outings or running errands due to the amount of care required by the participant (as age appropriate). This would include, but is not limited to, eloping, behavioral issues, medical issues, etc.

Part 2: Degree of Care

A) Toileting Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	4	5
Hands on, physical assistance, or completed by another	1	6	8
Completely Incontinent or on Bowel Program	1	6	8
Inappropriate toileting skills (throwing waste, not using restroom, etc.)	3	8	8

Response 0: The participant is independent and does not require assistance with tasks around toileting.

Responses 0, 4, or 5: The participant needs some assistance such as occasional physical assistance with cleaning, redressing, is on a bathroom schedule or needs prompts in order to prevent accidents.

Responses 1, 3, 6, or 8: For all four possible responses, this indicates the participant either needs supervision while toileting due to behaviors, needs regular cleaning after using the restroom, or is not able to use the bathroom to relieve themselves.

B) Bathing Skills

	Child 0-4	Child 5-17	Adult (18+)
Bathes without assistance	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Response 0: The participant is independent with bathing.

Responses 0, 2, or 3: Indicates a participant who needs prompts with completing bathing tasks, needs assistance getting into the shower, and needs to be checked prior to completing the task.

Responses 1 or 5: Indicates the participant needs to be physically bathed.

C) Grooming/ Hygiene Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Response 0: Indicates the participant does not need assistance with grooming.

Responses 0, 2, or 3: Indicates the participant needs to be reminded to complete their personal grooming and dressing tasks. This would be for a participant who needs to have their clothes picked out for them but is able to put them on or who needs assistance with a small tasks such as using buttons.

Responses 1 or 5: Indicates the participant needs to be physically dressed or have their personal hygiene/grooming task completed by a caregiver.

D) Eating Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	6	6	6
Tube Fed	8	8	8

Response 0: This participant does not need assistance with eating. This does not include meal preparation.

Responses 0, 2, or 3: This participant needs to be reminded to eat, supervised to make sure they do not choke, and/or prompted to finish eating.

Response 6: This participant would need someone to physically feed them because they do not have the capacity to hold a utensil and successfully get food from the plate and to their mouth.

Response 8: This participant receives all their nutrition from a G Tube.

E) Mobility Skills (In the home)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision to ambulate safely (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Response 0: This participant has no concerns with mobility. They are able to use a device without the assistance of a caregiver to navigate their home. If a device is being used and another response is selected the times that assistance is needed must be clearly documented in the annual assessment.

Response 2: This participant needs help occasionally to navigate certain areas of the home such as assistance getting around a corner in a wheelchair.

Responses 3 or 6: Indicates the participant has an unsteady gait and is at a high risk for falls.

Response 8: This participant is unable to navigate the entire house without the assistance of the caregiver. This participant would be classified as immobile.

F) Mobility Skills
(In the community)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Response 0: This participant does not need assistance in the community. They are able to use a device without the assistance of a caregiver to navigate their community. If a device is being used and another response is selected the times that assistance is needed has to be clearly documented in the annual assessment.

Response 2: This participant needs minimal assistance such as being assisted up steep hills or on rough terrain.

Responses 3 or 6: This participant is an elopement risk or is at a high risk for falls.

Response 8: This participant is unable to navigate the community without the assistance of the caregiver. This participant would be classified as immobile.

G) Vision

No vision problem	0
Some visual impairment (cannot be corrected with lenses)	2
Legally Blind but some light/shapes	4
Completely Blind	6

Response 0: The participant has no concerns with vision or the concerns are corrected with lenses.

Response 2: There is some visual impairment but not classified as legally blind. If glasses are listed on the annual assessment, the assessment must document why they are not addressing the vision issues.

Response 4: This is someone who is classified as legally blind but is still able to discern some features of their environment.

Response 6: This is for the participant who has no vision of any kind.

H) Receptive Communication	
No problem hearing or understanding spoken language	0
Partial hearing loss; limited understanding of spoken language	2
Little or no understanding of spoken language	7

Response 0: This person has no concern with hearing and their ability to understand what is being said to them.

Response 2: This participant has some hearing loss or if due to their disability they are unable to understand what is being said to them. They may require consistent repetition.

Response 7: This participant has no discernable ability to understand what is being said to them.

I) Expressive Communication	
Uses speech	0
Primarily uses gestures, sign language, communication board etc	2
Little or no expressive communication/ cannot express wants and needs	6

Response 0: This participant can express themselves verbally. This participant can express themselves enough for the caregiver to be able to know what the participant needs or wants. This is not assessing their ability to carry on a conversation.

Response 2: This participant can express themselves through signs, gestures, facial expressions, or a device. This participant can express themselves enough for the caregiver to be able to know what the participant needs or wants. This is not assessing their ability to carry on a conversation.

Response 6: This participant has almost no ability to let the caregiver know what they need or want.

J) Behavior		
	Under 50 lbs.	Over 50 lbs.
No significant behavior problems	0	0
Has frequent but manageable behavior problems	5	10
Has frequent, aggressive, and/or dangerous behavior problems	15	20

When assessing behaviors, all maladaptive behaviors demonstrated by the participant should be considered including but not limited to: PICA, aggressive behaviors, smearing feces, and behaviors associated with cognitive impairments and/or memory concerns (such as poor safety awareness, inappropriate interactions with strangers, etc.). Weight plays a factor in this question due to the differences in controlling physical outburst for individuals who weigh more.

Response 0: This indicates situations where the participant or their primary caregiver report that they have no concerns about the participant's behavior.

Responses 5 or 10: This indicates behaviors that are caused by the disability that cause significant disturbances in the household and does not include elopement/wandering as this is addressed under mobility skills (at home and in the community). These behaviors require time intensive intervention to address. If the behaviors are common among their typically developing peers such as talking too much or arguing with their siblings/parents these behaviors are not applicable to this section.

Response 20: This indicates behaviors that put the participant and their family in dangerous situations on a regular basis.

K) Seizures

No seizures, or completely controlled by medication	0
Occasional seizures, averaging about one per week	2
Frequent seizures, averaging more than one per week	5

Response 0: The participant does not have a diagnosed seizure disorder or it is controlled by medication.

Response 2: The participant has a seizure approximately once per week. If the participant is taking medication, its effect on the frequency of the participant's seizures needs to be clearly documented in the annual assessment.

Response 5: The participant has a seizure more than once per week. If the participant is taking medication, its effect on the frequency of the participant's seizures needs to be clearly documented in the annual assessment.

L) Medication

	Child 0-12	Child 13-17	Adult 18+
Takes no medication or is responsible for taking own medication	0	0	0
Takes own medication, but requires assistance	0	1	1
Medication must be administered for the participant	0	3	3

Response 0: This participant does not need assistance with opening bottles, remembering to take their medication, or is not regularly taking medication.

Responses 0 or 1: If the participant is able to willingly swallow their own medication but needs assistance with bottles or remembering to take their medication.

Responses 0 or 3: This participant has to have mediation administered as they are not able to swallow the medication without assistance or the medication has to be administered via G-tube or other method.

M) Prompting and Cuing

	Child 0-8	Child 9-17	Adult 18+
Requires no cuing, prompting and or redirection on average day	0	0	0
Requires occasional cuing, prompting or redirection throughout the day	0	2	2
Requires constant cuing/ prompting or redirecting throughout the day	1	6	6

Response 0: This participant does not need assistance through the day to stay on task or to complete daily living and personal hygiene tasks.

Responses 0 or 2: This participant only needs assistance with one area of daily living or personal hygiene tasks. This participant only needs prompts to stay on task with a few tasks such as homework or eating.

Responses 1 or 6: This participant needs prompts with the majority of their daily living and personal hygiene tasks.

N) Medical Status (Mark "Yes" in last column for all that apply)

	Score	Yes/No
Frequent suctioning	7	
Ventilator dependent	8	
Feeding tube	6	
Wound care	5	
Catheter care / change	5	
Range of motion exercises	8	
Trach care	4	
Repositioning	3	
Diabetes care	5	

If any of these tasks have been selected the need for it has to be clearly documented in the annual assessment.

O) Physical Health: Requires Care by a nurse or phsycian…

Rarely	0
Less than monthly	1
Monthly	2
Weekly	3
Daily	4

If the response is higher than a 1 the reasoning needs to be clearly documented in the annual assessment.

Part 3: Determine Amount of Break Justified

Directions: Go to the column with the supervision level calculated in part 1 (chart A), and the row with the level calculated from part 2 to determine appropriate amount of rest needed for caregiver

Part 2 Level:	Supervision Level 0	Supervision Level 1	Supervision Level 2	Supervision Level 3	Supervision Level 4	Supervision Level 5
1	0%	2%	6%	9%	13%	17%
2	0%	4%	7%	11%	15%	19%
3	0%	6%	9%	13%	17%	21%
4	0%	7%	11%	15%	19%	24%

Calculated percentage:

Part 3 is where the percentage is calculated and has to be manually entered into the spreadsheet. To determine the correct percentage locate the supervision level and go down until it intersects with the Level of Care amount produced by Part 2. For Example, a Supervision Level of 2 and a Level of Care of 3 would result in 9%.

Part 4: Schedule

Directions: The justified amount of respite is affected by other services that provide a break to the primary caregiver. Fill out the consumer's weekly schedule without showing the respite hours. Include all other services he/she receives. **It has been pre-filled with common sleep times but those can be erased/expanded. Each cell should either be left blank if Natural Supports or respite are used that hour, or have a service/activity keyed**

Leave times where the Primary Caregiver is responsible for care or where respite is delivered

From:	To:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12:00 AM	1:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
1:00 AM	2:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
2	3	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
3	4	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
4	5	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
5	6	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
6	7							
7	8							
8	9							
9	10							
10	11							
11AM	12PM							
12:00 PM	1:00 PM							
1	2							
2	3							
3	4							
4	5							
5	6							
6	7							
7	8							
8	9							
9	10							
10	11	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
11:00 PM	12:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
Count of Blank Hours		16	16	16	16	16	16	16

Total Hours of Natural Supports _____ **per week**

Percentage from Part 3 _____

Total Hours Per Week of Respite _____ **per week** (=Natural Supports per week x Percentage from Part 3)

Total Hours per MONTH of Respite _____ **per month** (= Respite Per week x 4.33)

*subject to adjustments in Part 5

The "Schedule" section of Part 4 is designed to be a visual representation of a typical week for the participant. All units of any personal care and day services on the support plan must be included on the schedule as the participant has the option to use those units. If the participant is of school age that time must be entered. If they are going to school for less than the typical hours the reason must be documented in the annual assessment. If the participant is home schooled the time spent on school work must be included along with the legal classification for their type of homeschooling. If the participant is on home bound the time the teacher is at the home must be included. If the parents are separated or divorced and have a visitation schedule that must be included in Part 6 and must note how respite will be used or split among the parents. Sleep is included on the schedule in order to make completion easier (so as not to have to enter in those hours). These hours can be adjusted but if the total amount of sleep has been significantly adjusted the reasoning must be documented in Part 6.

Caregiver Self Assessment Enter an "X" into the correct cell to indicate a "yes" or "no" answer.

*** Attach a copy of the completed *AMA Caregiver Self-Assessment Questionnaire* with this form.**

Did the caregiver answer "Yes" to either or both Questions 4 and 11?		Yes		No
Did the caregiver's total "Yes" scores equal 10 or more? (reverse #5 and #15)		Yes		No
Was the caregiver's score on question 17 equal to 6 or higher?		Yes		No
Was the caregiver's score on question 18 equal to 6 or higher?		Yes		No

Total "Yes" Scores:	0	1 "Yes" score results in a 10% increase (min. 5), 2 "Yes" Scores result in a 15% increase (min. 5)
Percent Increase:		3 "Yes" Scores result in a 20% increase (min. 10), 4 "Yes" Scores result in a 25% increase (min 10).

Adjusted Total Hours per MONTH of Respite _____ **per month**

The Caregiver Self-Assessment section of part four is intended to assess the stress level of the caregiver(s). This assessment should consider a typical week experienced by the caregiver(s), rather than "the last week or so". To complete this section, the case manager should provide **page one** of the American Medical Association's "Caregiver Self-Assessment Questionnaire" to the waiver participant's caregiver for completion. The assessment can be completed over the phone (with the case manager marking the caregiver's responses on the form), during a home visit, by mail, etc. The completed assessment will assist with gauging the caregiver's level of stress.

Once the caregiver's responses have been recorded on page one, the **case manager** will follow the directions on **page two** of the questionnaire to score the Self-Assessment Questionnaire.

When determining the score:

1. Reverse score questions 5 and 15. (For example, a "No" response should be counted as "Yes" and a "Yes" response should be counted as "No")

2. Total the number of "yes" responses.

Next, the Case Manager should enter the results into this section of the Respite Assessment.

The amount of respite required will be adjusted based on the caregiver's self-assessed level of stress.

Part 5: Adjustments

Directions: Check the yes box, for all that apply to you and provide additional comments if desired.

	Yes	If Yes, Explain:
Is there only one caregiver?		
Is the caregiver 65+ years old?		
Does the work schedule of the caregiver impact the need for care and supervision? If yes, provide the work schedule below in Part 6: Additional Justification Section.		
Does the caregiver provide care to another individual with significant health issues?		
Is the caregiver responsible for another dependent that has special needs?		
Is the caregiver responsible for another dependent that does not have special needs/health issues? If Yes, indicate how many in the "Explain" box.		
Does the caregiver have significant health problems?		
Is the caregiver unable to sleep consistently due to the care of the participant?		

For every answer the caregiver answers yes to in Part 5, 5 additional hours per month can be added to calculated need (For IDRD: Up to 68 hours which is the maximum).

Total Adjustments: **0**

Adjusted Assessed Need: _____ **hours per month**

1. If there is only one caregiver the answer is yes. If there are two parents in the home and this question is marked as "yes" it must be documented that the other parent is not able to provide care or support.
2. If the caregiver is over 65 the answer is yes. The caregiver's age must be clearly documented at the top of the assessment.
3. If the caregiver's work schedule impacts the need for care and supervision the answer is "yes". Provide the caregiver's work schedule in section 6.
4. If the caregiver provides care to another individual with significant health issues, the answer is "yes". Provide specifics in the explanation box.
5. If the caregiver is caring for another child or dependent that has a diagnosed disability, the answer is "yes". Provide specifics in the explanation box.
6. If the caregiver is caring for another child or dependent that does not have a diagnosed disability, the answer is "yes". Provide specifics (quantity and ages of other dependents) in the explanation box.
7. If the caregiver has a health problem *that impedes their ability to provide care* the answer is "yes". The health concern must be included in the "If, Yes, Explain" section.
8. If the participant interrupts the caregiver's sleep due to behaviors or health monitoring then the answer is "yes".

For ID/RD and CS Waivers:

ID/RD WAIVER ONLY:

Does this individual qualify for the Respite Exception? _____ Yes _____ No

If Yes, which category of Respite Exception? Check the Waiver Manual for details about each category.

(Justify the selected category in next section)

_____ Caregiver hospitalized or receiving medical treatment

_____ Need for contant hands-on/direct care and supervision due to medically complex condition

_____ Need for contant hands-on/direct care and supervision due to severe disability

_____ Seasonal relief during the summer (June, July, August) for a school student over age 12

*Be sure the CM Annual Assessment (and/or other documents) clearly and specifically reflect the care and supervision needs of the person for whom respite is requested.

Total Requested Respite Units (Hours) after the exception: _____ (CM Enter total amount needed per month)

CS WAIVER ONLY:

Does this require additional supports due to Summer Break from School? _____ Yes _____ No

Total Requested Respite Units (Hours) for Summer months: _____ (CM Enter total amount needed per month for June/July/Aug)

This section is used to indicate when the person meets a category for Exception (for ID/RD) or simply requires more hours than the schedule reflects (for CS – if the schedule reflects school). Please refer to the Waiver Manual for details about each category.

Part 6: Additional Justification (Optional): **about 500 words or 38 lines, attach additional info if needed**

If you wish to request more respite units than this tool assigns, please provide additional justification for the need for more respite hours than the respite assessment demonstrated. Include (if necessary) the work schedule of the caregivers.

Part 7: Final Assessed Need

Assessed Respite Units (Hours): _____ per _____*

*(For ID/RD Waiver: If over the limits in the Waiver then additional justification should be provided to show that institutionalization will take place without this service.)

Individual Completing the Form Name/Title: _____

Date Completed: _____

Part 6 is available if Part 7 requests more units than what is determined by the assessment. This does not need to be a narrative retelling of the assessment. It is to provide additional information to explain why the amount assessed will not meet the participant's need such as the parent's health, behaviors that cause the participant to leave school early, single caregiver's work schedule, etc.

South Carolina Department of Disabilities and Special Needs
Respite Assessment for HASCI Waiver

This Respite Assessment should be completed by the Case Manager with input from the Waiver Participant, Family/Caregiver, and other service providers.

Participant: _____

DOB: _____

DSN Board/Provider: _____ CM/EI: _____

Participant's Primary Caregiver(s):
Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Participant's Primary Diagnosis: _____
If Other: _____

Additional Diagnoses (List all that apply):

_____

Is this participant on the SCDDSN Critical Circumstances List for Residential Services? _____

Is the primary caregiver being paid to provide personal care services to the participant? _____

Part 1: Amount of Supervision Necessary:

Directions: to determine the level of supervision needed for the participant find the column with his/her age and the row that on average most closely matches the amount of supervision necessary during awake hours
What level of monitoring does the client typically require during awake hours?

	Child 0-4	Child 5-11	Child 12-17	Adult 18+
Can be left unattended for extended periods of time			0	0
Can be left unattended for several hours at a time (2-4 hours) to engage in independent activities, but needs access to a support person daily for guidance or assistance			1	1
Can be left unattended for short periods of time (1-2 hours), provided that the environment is strictly structured and that a support person can respond quickly in an emergency situation			2	2
Can be left unattended for very short periods of time (while caregiver steps to a neighbors or checks the mail) but no longer than 30 minutes		2	3	3
Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours	1	3	4	4
Cannot be left unattended. Requires a support person within the room or within earshot of the participant's location at all times during awake hours	3	5	5	5

Is the caregiver prevented from going on public outings or running errands due to the amount of care required by the participant (as age appropriate)?	_____	If Yes, add one (1) point to the Supervision Score (max 5)

Supervision Level _____

Explain the indicated Supervision Level (Justify the number you chose above) REQUIRED:

Part 2: Degree of Care

Directions: To determine the Degree of care for the participant, go to the column with the participant's age and the row that matches the participant's skill level and circle the score in that box. For part N, check all that apply. Add all of the circled scores together to determine degree of care score, use the score to determine degree of care level.

A) Toileting Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	4	5
Hands on, physical assistance, or completed by another	1	6	8
Completely Incontinent or on Bowel Program	1	6	8
Inappropriate toileting skills (throwing waste, not using restroom, etc.)	3	8	8

Score: _____

B) Bathing Skills

	Child 0-4	Child 5-17	Adult (18+)
Bathes without assistance	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Score: _____

C) Grooming/ Hygiene Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Score: _____

D) Meal Preparation/Eating Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	6	6	6
Tube Fed	8	8	8

Score: _____

E) Mobility Skills (In the home)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision to ambulate safely (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Score: _____

South Carolina Department of Disabilities and Special Needs
Respite Assessment for HASCI Waiver

F) Mobility Skills (In the community)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Score: _____

G) Vision

No vision problem	0
Some visual impairment (cannot be corrected with lenses)	2
Legally Blind but some light/shapes	4
Completely Blind	6

Score: _____

H) Receptive Communication

No problem hearing or understanding spoken language	0
Partial hearing loss; limited understanding of spoken language	2
Little or no understanding of spoken language	7

Score: _____

I) Expressive Communication

Uses speech	0
Primarily uses gestures, sign language, communication board, etc.	2
Little or no expressive communication/cannot express wants and needs	6

Score: _____

J) Behavior

	Under 50 lbs.	Over 50 lbs.
No significant behavior problems	0	0
Has frequent but manageable behavior problems	5	10
Has frequent, aggressive, and/or dangerous behavior problems	15	20

Score: _____

K) Seizures

No seizures, or completely controlled by medication	0
Occasional seizures, averaging about one per week	2
Frequent seizures, averaging more than one per week	5

Score: _____

L) Medication

	Child 0-12	Child 13-17	Adult 18+
Takes no medication or is responsible for taking own medication	0	0	0
Takes own medication, but requires assistance	0	1	1
Medication must be administered for the participant	0	3	3

Score: _____

M) Prompting and Cuing

	Child 0-8	Child 9-17	Adult 18+
Requires no cuing, prompting and or redirection on average day.	0	0	0
Requires occasional cuing, prompting or redirection throughout the day	0	2	2
Requires constant cuing/ prompting or redirecting throughout the day	1	6	6

Score: _____

N) Medical Status (Mark "Yes" in last column for all that apply)

	Score	Yes/No
Frequent suctioning	7	
Ventilator dependent	8	
Feeding tube	6	
Wound care	5	
Catheter care / change	5	
Range of motion exercises	8	
Trach care	4	
Repositioning	3	
Diabetes care	5	

Score: _____

O) Physical Health: Requires Care by a nurse or physician…

Rarely	0
Less than monthly	1
Monthly	2
Weekly	3
Daily	4

Score: _____

TOTAL SCORE FOR PART 2: _____ **Part 2 Level:** _____

Level 1: 0 – 10 Level 2: 11 – 30 Level 3: 31 – 40 Level 4: 41 – 80+

Part 3: Determine Amount of Break Justified

Directions: Go to the column with the supervision level calculated in part 1 (chart A), and the row with the level calculated from part 2 to determine appropriate amount of rest needed for caregiver

Part 2 Level:	Supervision Level 0	Supervision Level 1	Supervision Level 2	Supervision Level 3	Supervision Level 4	Supervision Level 5
1	0%	2%	6%	9%	13%	17%
2	0%	4%	7%	11%	15%	19%
3	0%	6%	9%	13%	17%	21%
4	0%	7%	11%	15%	19%	24%

Calculated percentage: _____

This percentage is the percentage of time that the family can have covered by Respite Services (in addition to the time in Part 4). Example: If mom is responsible for Johnny's care whenever he is not at school, not with the PCA, or sleeping then it may add up to 57 hours a week of care. If he was Supervision Level 3 and Part Two Score at Level 3 then he would get 13% of 57 hours a week of respite (57 x 13% = 7.4 hours a week or 32 hours a month).

Part 4: Schedule

Directions: The justified amount of respite is affected by other services that provide a break to the primary caregiver. Fill out the participant's weekly schedule without showing the respite hours. Include all other services he/she receives. **It has been pre-filled with common sleep times but those can be erased/expanded. Each cell should either be left blank if Natural Supports or respite are used that hour, or have a service/activity keyed into them.**

Leave times where the Primary Caregiver is responsible for care or where respite is delivered BLANK.

From:	To:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12:00 AM	1:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
1:00 AM	2:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
2	3	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
3	4	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
4	5	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
5	6	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
6	7							
7	8							
8	9							
9	10							
10	11							
11AM	12PM							
12:00 PM	1:00 PM							
1	2							
2	3							
3	4							
4	5							
5	6							
6	7							
7	8							
8	9							
9	10							
10	11	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
11:00 PM	12:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
Count of Blank Hours		16	16	16	16	16	16	16

Total Hours of Natural Supports _____ **per week**
Percentage from Part 3 _____
Total Hours Per Week of Respite _____ **per week** (=Natural Supports per week x Percentage from Part 3)

Total Hours per MONTH of Respite _____ **per month** (= Respite Per week x 4.33)

Caregiver Self Assessment

Enter an "X" into the correct cell to indicate a "yes" or "no" answer.

*** Attach a copy of the completed *AMA Caregiver Self-Assessment Questionnaire* with this form.**

Did the caregiver answer "Yes" to either or both Questions 4 and 11?		_____	Yes	_____ No
Did the caregiver's total "Yes" scores equal 10 or more?	(reverse #5 and #15)	_____	Yes	_____ No
Was the caregiver's score on question 17 equal to 6 or higher?		_____	Yes	_____ No
Was the caregiver's score on question 18 equal to 6 or higher?		_____	Yes	_____ No

Total "Yes" Scores: 0
Percent Increase: _____

1 "Yes" score results in a 10% increase (min. 5), 2 "Yes" Scores result in a 15% increase (min. 5)
3 "Yes" Scores result in a 20% increase (min. 10), 4 "Yes" Scores result in a 25% increase (min 10).

Adjusted Total Hours per MONTH of Respite _____ **per month**

Part 5: Adjustments

Directions: Check the yes box, for all that apply to you and provide additional comments if desired.

	Yes	If Yes, Explain:
Is there only one caregiver?		
Is the caregiver 65+ years old?		
Does the work schedule of the caregiver impact the need for care and supervision? If yes, provide the work schedule below in Part 6: Additional Justification Section.		
Does the caregiver provide care to another individual with significant health issues?		
Is the caregiver responsible for another dependent that has special needs?		
Is the caregiver responsible for another dependent that does not have special needs/health issues? If Yes, indicate how many in the "Explain" box.		
Does the caregiver have significant health problems?		
Is the caregiver unable to sleep consistently due to the care of the participant?		

For every answer the caregiver answers yes to in Part 5, 5 additional hours per month can be added to calculated need.

Total Adjustments: **0**

Adjusted Assessed Need: _____ **hours per month**

Part 6: Additional Justification (Optional)

If you wish to request more respite units than this tool assigns, please provide additional justification for the need for more respite hours than the respite assessment demonstrated. Include (if necessary) the work schedule of the caregivers.

Part 7: Final Assessed Need

Assessed Respite Units (Hours): _____ per _____ *

Individual Completing the Form Name/Title: _____

Date Completed: _____

South Carolina Department of Disabilities and Special Needs
ID/RD and CS Waiver Respite Assessment

This Respite Assessment should be completed by the Case Manager with input from the Waiver Participant, Family/Caregiver, and other service providers.

Participant Name: _____

DOB _____

DSN Board/Provider: _____ CM/EI: _____

Participant's Primary Caregiver(s):
Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Participant's Primary Diagnosis: _____
If Other: _____

Additional Diagnoses (List all that apply):

_____

Is this Participant on the SCDDSN Critical Circumstances List for Residential Services? _____

Is the primary caregiver being paid to provide personal care services to the consumer? _____

Part 1: Amount of Supervision Necessary:

Directions: to determine the level of supervision needed for the participant find the column with his/her age and the row that on average most closely matches the amount of supervision necessary during awake hours

What level of monitoring does the client typically require during awake hours?

	Child 0-4	Child 5-11	Child 12-17	Adult 18+
Can be left unattended for extended periods of time			0	0
Can be left unattended for several hours at a time (2-4 hours) to engage in independent activities, but needs access to a support person daily for guidance or assistance			1	1
Can be left unattended for short periods of time (1-2 hours), provided that the environment is strictly structured and that a support person can respond quickly in an emergency situation			2	2
Can be left unattended for very short periods of time (while caregiver steps to a neighbors or checks the mail) but no longer than a 30 minutes		2	3	3
Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours	1	3	4	4
Cannot be left unattended. Requires a support person within the room or within earshot of the client's location at all times during awake hours	3	5	5	5

Is the caregiver prevented from going on public outings or running errands due to the amount of care required by the participant (as age appropriate)?	_____	If Yes, add one point to the Supervision Score (max 5)

Supervision Level _____ **Justify this Level in the next section.

Explain the indicated Supervision Level (Justify the number you chose above) REQUIRED: (contains roughly 170 words/12 lines, attach additional info if needed)

Part 2: Degree of Care

Directions: To determine the Degree of care for the participant, go to the column with the participant's age and the row that matches the participant skill level and circle the score in that box. For part N, circle all that apply. Add all of the circled scores together to determine degree of care score, use the score to determine degree of care level.

A) Toileting Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	4	5
Hands on, physical assistance, or completed by another	1	6	8
Completely Incontinent or on Bowel Program	1	6	8
Inappropriate toileting skills (throwing waste, not using restroom, etc.)	3	8	8

Score: _____

B) Bathing Skills

	Child 0-4	Child 5-17	Adult (18+)
Bathes without assistance	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Score: _____

C) Grooming/ Hygiene Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	1	5	5

Score: _____

D) Eating Skills

	Child 0-4	Child 5-17	Adult (18+)
No assistance needed	0	0	0
Prompts, reminders or supervision needed	0	2	3
Hands on, physical assistance, or completed by another	6	6	6
Tube Fed	8	8	8

Score: _____

E) Mobility Skills (In the home)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision to ambulate safely (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Score: _____

South Carolina Department of Disabilities and Special Needs
ID/RD and CS Waiver Respite Assessment

F) Mobility Skills (In the the community)

	Under 50 lbs.	Over 50 lbs.
Walks independently or uses device for independent mobility	0	0
Requires minimal assistance	2	2
Needs constant supervision (eloping/wandering)	3	6
Is not mobile/requires physical assistance with all tasks	8	8

Score: _____

G) Vision

No vision problem	0
Some visual impairment (cannot be corrected with lenses)	2
Legally Blind but some light/shapes	4
Completely Blind	6

Score: _____

H) Receptive Communication

No problem hearing or understanding spoken language	0
Partial hearing loss; limited understanding of spoken language	2
Little or no understanding of spoken language	7

Score: _____

I) Expressive Communication

Uses speech	0
Primarily uses gestures, sign language, communication board etc.	2
Little or no expressive communication/ cannot express wants and needs	6

Score: _____

J) Behavior

	Under 50 lbs.	Over 50 lbs.
No significant behavior problems	0	0
Has frequent but manageable behavior problems	5	10
Has frequent, aggressive, and/or dangerous behavior problems	15	20

Score: _____

K) Seizures

No seizures, or completely controlled by medication	0
Occasional seizures, averaging about one per week	2
Frequent seizures, averaging more than one per week	5

Score: _____

L) Medication

	Child 0-12	Child 13-17	Adult 18+
Takes no medication or is responsible for taking own medication	0	0	0
Takes own medication, but requires assistance	0	1	1
Medication must be administered for the participant	0	3	3

Score: _____

M) Prompting and Cuing

	Child 0-8	Child 9-17	Adult 18+
Requires no cuing, prompting and or redirection on average day	0	0	0
Requires occasional cuing, prompting or redirection throughout the day	0	2	2
Requires constant cuing/ prompting or redirecting throughout the day	1	6	6

Score: _____

N) Medical Status (Mark "Yes" in last column for all that apply)

	Score	Yes/No
Frequent suctioning	7	
Ventilator dependent	8	
Feeding tube	6	
Wound care	5	
Catheter care / change	5	
Range of motion exercises	8	
Trach care	4	
Repositioning	3	
Diabetes care	5	

Score: _____

O) Physical Health: Requires Care by a nurse or physician…

Rarely	0
Less than monthly	1
Monthly	2
Weekly	3
Daily	4

Score: 10

TOTAL SCORE FOR PART 2: _____ **Part 2 Level:** _____

Level 1: 0 – 10 Level 2: 11 – 30 Level 3: 31 – 40 Level 4: 41 – 80+

Part 3: Determine Amount of Break Justified

Directions: Go to the column with the supervision level calculated in part 1 (chart A), and the row with the level calculated from part 2 to determine appropriate amount of rest needed for caregiver

Part 2 Level:	Supervision Level 0	Supervision Level 1	Supervision Level 2	Supervision Level 3	Supervision Level 4	Supervision Level 5
1	0%	2%	6%	9%	13%	17%
2	0%	4%	7%	11%	15%	19%
3	0%	6%	9%	13%	17%	21%
4	0%	7%	11%	15%	19%	24%

Calculated percentage: _____ *

*This percentage is the percentage of time that the family can have covered by Respite Services (in addition to the time in Part 4). Example: If mom is responsible for Johnny's care whenever he is not at school, not with the PCA, or sleeping then it may add up to 57 hours a week of care. If he was Supervision Level 3 and Part Two Score at Level 3 then he would get 13% of 57 hours a week of respite (57 x 13% = 7.4 hours a week or 32 hours a month).

Part 4: Schedule

Directions: The justified amount of respite is affected by other services that provide a break to the primary caregiver. Fill out the participant's weekly schedule without showing the respite hours. Include all other services he/she receives. It has been pre-filled with common sleep times but those can be erased/expanded. Each cell should either be left blank if Natural Supports or respite are used that hour, or have a service/activity keyed into them.

Leave times where the Primary Caregiver is responsible for care or where respite is delivered BLANK.

From:	To:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12:00 AM	1:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
1:00 AM	2:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
2	3	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
3	4	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
4	5	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
5	6	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
6	7							
7	8							
8	9							
9	10							
10	11							
11AM	12PM							
12:00 PM	1:00 PM							
1	2							
2	3							
3	4							
4	5							
5	6							
6	7							
7	8							
8	9							
9	10							
10	11	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
11:00 PM	12:00 AM	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep	Sleep
Count of Blank Hours		16	16	16	16	16	16	16

Total Hours of Natural Supports _____ **per week**

Percentage from Part 3 _____

Total Hours Per Week of Respite _____ **per week** (=Natural Supports per week x Percentage from Part 3)

Subtotal Hours per MONTH of Respite _____ **per month** (= Respite Per week x 4.33)

Caregiver Self Assessment

Enter an "X" into the correct cell to indicate a "yes" or "no" answer.

*** Attach a copy of the completed *AMA Caregiver Self-Assessment Questionnaire* with this form.**

Did the caregiver answer "Yes" to either or both Questions 4 and 11?	Yes	No
Did the caregiver's total "Yes" scores equal 10 or more? (reverse #5 and #15)	Yes	No
Was the caregiver's score on question 17 equal to 6 or higher?	Yes	No
Was the caregiver's score on question 18 equal to 6 or higher?	Yes	No

Total "Yes" Scores: 0

Percent Increase: _____

1 "Yes" score results in a 10% increase (min. 5), 2 "Yes" Scores result in a 15% increase (min. 5)
3 "Yes" Scores result in a 20% increase (min. 10), 4 "Yes" Scores result in a 25% increase (min 10).

Adjusted Total Hours per MONTH of Respite _____ **per month**

Part 5: Adjustments

Directions: Check the yes box, for all that apply to you and provide additional comments if desired.

	Yes	If Yes, Explain:
Is there only one caregiver?		
Is the caregiver 65+ years old?		
Does the work schedule of the caregiver impact the need for care and supervision? If yes, provide the work schedule below in Part 6: Additional Justification Section.		
Does the caregiver provide care to another individual with significant health issues?		
Is the caregiver responsible for another dependent that has special needs?		
Is the caregiver responsible for another dependent that does not have special needs/health issues? If Yes, indicate how many in the "Explain" box.		
Does the caregiver have significant health problems?		
Is the caregiver unable to sleep consistently due to the care of the participant?		

For every answer the caregiver answers yes to in Part 5, 5 additional hours per month can be added to calculated need (For IDRD: Up to 68 hours which is the maximum).

Total Adjustments: **0**

Adjusted Assessed Need: _____ **hours per month**

ID/RD WAIVER ONLY:

Does this individual qualify for the Respite Exception? _____ Yes _____ No

If Yes, which category of Respite Exception? Check the Waiver Manual for details about each category.

(Justify the selected category in next section)

_____ Caregiver hospitalized or receiving medical treatment

_____ Need for constant hands-on/direct care and supervision due to medically complex condition

_____ Need for constant hands-on/direct care and supervision due to severe disability

_____ Seasonal relief during the summer (June, July, August) for a school student over age 12

*Be sure the CM Annual Assessment (and/or other documents) clearly and specifically reflect the care and supervision needs of the person for whom respite is requested.

Total Requested Respite Units (Hours) after the exception: _____ (CM Enter total amount needed per month)

CS WAIVER ONLY:

Does this require additional supports due to Summer Break from School? _____ Yes _____ No

Total Requested Respite Units (Hours) for Summer months: _____ (CM Enter total amount needed per month for June/July/Aug)

Part 6: Additional Justification (Optional): about 500 words or 38 lines, attach additional info if needed

If you wish to request more respite units than this tool assigns, please provide additional justification for the need for more respite hours than the respite assessment demonstrated. Include (if necessary) the work schedule of the caregivers.

Part 7: Final Assessed Need

Assessed Respite Units (Hours): _____ per _____ *

*(For ID/RD Waiver: If over the limits in the Waiver then additional justification should be provided to show that institutionalization will take place without this service.)

Individual Completing the Form Name/Title: _____

Date Completed: _____