EVALUATION FOR COMMUNITY LIVING

Name:_____ DOB:_____

SSN:_____ Date:_____

This evaluation is to be completed by the Interdisciplinary Team after appropriate information and an explanation of other settings and possible services have been given to the resident, his/her legal guardian or surrogate consent giver (if applicable) and anyone who assists this person with decision making. Indicate when and how information and an explanation of other settings and possible services were provided and to whom:

I. Interest

1. This person or his/her legal guardian or surrogate consent giver) expresses an interest or desire to live in a setting other than an ICF/IID:

   ☐No, stop; do not proceed with evaluation.

   ☐Yes, proceed with evaluation.

   How was this interest or desire (or lack of) expressed and by whom?

   _____

2. Which best describes this person's (or legal guardian's or surrogate consent giver's) interest/desire regarding a move from this ICF/IID:

   ☐Interested – will move but will be selective regarding choice of location, situation, provider, etc.

   ☐Strongly desires - Is ready to move as soon as possible.

3. Where does this person wish to live; what are his/her preferences? Include as much information as possible (i.e., close to family, in a specific town or city, alone/without others with disabilities, in house with others and staff, must have own bedroom/single occupancy bedroom, etc.).

   _____

4. If he/she expresses a preference to live with his/her family/"at home," is that a true possibility?

   ☐Yes ☐No

   If no, give detailed explanation including date of conversation with family during which information about the person's preferences and services that could support him/her if such a move occurred and the specific results of the conversation.

   _____

5. Which best describes the interest/desire of this person's family regarding a move from this ICF/IID:

☐Interested – will support a move, but will be selective regarding choice of location, situation, provider, etc.

☐Strongly desires - Is ready for a move as soon as possible.

☐Does not want the resident to move.

☐No family involvement.

Who/which family members were contacted?

_____

When were they contacted?

_____

How were they contacted? (*i.e., phone, letter, etc.*)

_____

II. Capacity

1. Does this person currently meet ICF/IID Level of Care?

☐Yes ☐No

2. Can this person's needs be met and his/her progress toward independence continue without the continuous, aggressive consistent implementation of training and treatment programs?

☐Yes ☐No

3. What medications (oral, topical and/or injectable) are prescribed to this person and what is the frequency/schedule for administration?

_____

4. What medical treatments or skilled nursing tasks are ordered by a physician on this person's behalf? (Include the frequency/schedule for the treatments/tasks.)

_____

5. Does this person have a condition for which a special diet is prescribed?

☐Yes ☐No

If yes, does a registered dietician monitor the person and the diet regularly?

☐Yes ☐No

6. Does this person take medication for behavior control?

☐Yes ☐No

If yes, how often does he/she receive services from a psychologist (monitoring of plan, staff training for program implementation, counseling, re-assessment, program revision, etc.)?

_____

7. Are there any other care or supervision needs; including any critical interventions necessary for maintaining this person's health and safety or the health and safety of others (i.e., requires 1:1 supervision; requires assistance with transfers; cannot evacuate building without physical assistance; PICA; etc.)?

☐Yes ☐No

If yes, explain:

_____

8. Indicate which ID/RD Waiver services would likely be needed if living outside of the ICF/IID:

☐Adult Attendant Care Services

☐Adult Companion Services

☐Adult Day Health Care

☐Adult Day Health Care Nursing

☐Adult Day Health Care Transportation

☐Adult Dental Services

☐Adult Vision

☐Audiology Services

☐Behavior Support Services

☐Career Preparation Services

☐Community Services

☐Day Activity

☐Employment Services

☐Environmental Modifications

☐Nursing Services

☐Personal Care I

☐Personal Care II

☐Personal Emergency Response System (PERS)

☐Private Vehicle Modifications

☐Residential Habilitation

☐Respite Care

☐Specialized Medical Equipment, Supplies and Assistive Technology

☐Support Center Services

Evaluator (Participating Interdisciplinary Team Members)	**Title**