**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
**SUPPORTED LIVING I (SLP-I) ASSESSMENT**

Provider Agency Responsible for Residential Habilitation:______________________________________________

Date of Assessment:________________________ Assessment Completed By:_______________________________

Participant's Name:_____________________________________________________________________________

Address *(include zip code)*:______________________________________________________________________

Purpose: ☐Annual Review ☐New Site

**The SLP-I Assessment is participant and location specific. This assessment is not transferrable. The Assessment must be completed prior to receiving residential habilitation and annually thereafter. Any item unmet at the time of review requires an explanation and a detailed description of the plan to address the issue. If the person moves to another location, a new assessment must be completed. The assessment must be kept on file at the Provider site and a copy sent to DDSN via email at license@ddsn.sc.gov.**

| # | REQUIREMENT | SCORE | COMMENTS | PLAN TO ADDRESS ISSUE | COMPLETION DATE |
|---|---|---|---|---|---|
| 1 | Hot and cold running water. *(If water temperature exceeds 130 degrees, assessment results must be available to show that the person is capable of regulating the temperature and is not at risk.)* | ☐YES ☐NO | | | |
| 2 | Functioning heating system. | ☐YES ☐NO | | | |
| 3 | Operable electricity. | ☐YES ☐NO | | | |
| 4 | Functioning tub or shower with hot and cold running water. | ☐YES ☐NO | | | |
| 5 | Mattress and bedding for each resident *(married couples may elect to share a bed).* | ☐YES ☐NO | | | |
| 6 | Functional toilet. | ☐YES ☐NO | | | |
| 7 | Lockable doors and windows. | ☐YES ☐NO | | | |
| 8 | Sanitary environment. | ☐YES ☐NO | | | |
| 9 | Free from obvious hazards. | ☐YES ☐NO | | | |
| 10 | Medications stored safely on site unless contraindicated. *(If contraindicated, a plan must be available for how/where medications will be stored.)* | ☐YES ☐NO | | | |
| 11 | When more than one resident lives in a site, there is sufficient space and opportunity for privacy *(bathroom and bathing facilities must be behind lockable doors, lockable doors on bedroom/ sleeping areas, each person must have lockable storage).* | ☐YES ☐NO | | | |

| | | | | | |
|---|---|---|---|---|---|
| 12 | For residents unable to self-medicate, a log is maintained which records:<br><br>• Name of medication.<br>• Name of staff giving medication.<br>• Time and date medication was given.<br>• Amount of medication given. | ☐YES ☐NO | | | |
| 13 | Resident successfully demonstrates the ability to evacuate the site in under three (3) minutes in response to fire alarm *(Prior to receiving residential habilitation and annually thereafter).* | ☐YES ☐NO | | | |
| 14 | The site has at least one fire extinguisher that is operable. | ☐YES ☐NO | | | |

The Provider Agency listed above attests to their ability to demonstrate compliance with DDSN Directives, Administrative and Service Standards, and Medicaid Policies. This includes, but is not limited to: compliance with Residential Habilitation Standards, Administrative Agency Standards, Staff Qualifications and Training Requirements, Medication Administration Requirements, Infection Control Procedures, Incident Management Reporting (including allegations of Abuse/Neglect/Exploitation, Critical Incidents, and Death Reporting), Human Rights Committees, Risk Management, Quality Management, and timely handling of participant grievances.

The results of this assessment are correct as of the date of assessment and I understand the assessment must be completed annually or whenever the participant moves to a new location. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD: Certification and Licensure of DDSN Residential and Day Facilities, and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

Print Name:_______________________________________ Date:_______________________

_______________________________________

Signature of Executive Director/CEO of Provider Agency

****A copy of the Assessment must be maintained in the Participant's Case Management and Residential Habilitation Provider files. All Supported Living participants must be included in the DDSN database for Residential Habilitation.****