

Instructions for Completing the Case Management Comprehensive Assessment Form

The assessment was designed to provide a comprehensive picture of the person. The assessment is intended to be a positive, consumer driven tool, which identifies what the consumer is doing, and what the consumer wants to do in the future. In addition, the assessment includes a Risk Assessment that was developed to identify health and safety risks in order to reduce the risk of harm. The items were chosen based on their ability to assess needs and strengths as well as risk. As a result, the individual items and the entire assessment lend themselves to developing interventions and programming for the Comprehensive Service Plan.

Purpose of the Assessment/Reassessment

- To identify the consumer's areas of deficits, strengths, and preferences
- To identify any barriers to maintaining the consumer's current level of functioning;
- To identify health and safety risks in order to reduce the risk of harm through interventions, resources, and service activities.
- To determine the need for any medical, social, educational, housing, transportation, vocational or other services
- To provide the foundation for developing the Comprehensive Service Plan and the Crisis Intervention Plan.

Format

The assessment is divided into domain areas for Medical and Physical Health; Mental Health, Behavioral, and Substance Abuse; Housing and Environment; Social; Transportation, Education, and Vocational.

Most questions are worded as you would ask them directly to the consumer. In the case that you are asking them of someone else such as a parent or guardian, you can change the wording to fit the situation. For example, "Do you have any health problems that require assistance to manage?" could be reworded to say "Does Jane have any health problems that require assistance to manage?" Other questions are meant to be completed by the case manager. These are labeled "ASSESSOR". All of the Risk Assessment sections are meant to be completed by the case manager, rather than directly asking the consumer or guardian.

The assessment can be used for both children and adults, although certain sections may pertain only to one or the other. These sections are clearly labeled as such.

Sometimes a question won't quite fit the particular consumer. In this case, please check the answer that you think best fits the particular consumer and use the comment box to provide additional information. You may also use other sources of information such as medical records or reports from providers. This may be particularly helpful in the medical and physical health section if the consumer has difficulty recalling specific information. Any records used should be noted in the "Additional records reviewed" field in the consumer information section.

Most of the questions are in a yes/no or a limited choice format. However, most questions have a comment area intended to provide space for the case manager to provide additional information about a particular question. Since the Chapter 24 Administrative Rules require that the Assessment be completed in a narrative format, **it is very important that the case manager provide written comments to provide a clear picture of the consumer life and**

abilities at the time of the assessment. The information in the comment area should be written in complete sentences.

Additionally, there is an area at the end of each section to specify the consumer's needs, wants, and desired results for that section. This includes the consumer's strengths and preferences. The information in this summary will be useful in developing the Comprehensive Service Plan.

Technical Instructions

- The form has been set up so that the case manager can enter information in designated areas.
- **Yes/No Questions.** Most of the questions are yes/no or a limited choice format. (To “check” a box, you simply need to place the cursor over the box you want to check and either “click” with the mouse or use the Space Bar).
- **Comment Boxes.** Text boxes are provided for the case manager to use to provide more information in a narrative format. When completing the form, it is important for the case manager to be as comprehensive as possible and provide a sufficient amount of information to provide a clear understanding of the consumer.

Organization

The assessment information is organized as follows:

- **Consumer Information.** This section provides consumer and assessor identification, type of assessment, qualifying population group, and persons providing information for the assessment. It also includes basic demographic, financial, and contact information for the consumer and their legal representatives.
 - **FAQs**
 - *Why doesn't the “Language” item ask whether the person is non-verbal?* “Language” refers to whether the consumer and/or legal representative speak English or need interpreter services. The Medical and Social sections of the assessment include questions pertaining to the consumer's ability to communicate. Use those sections to indicate if the person is non-verbal and how needs are communicated.
 - *What is meant by “Are any siblings receiving Waiver Services?”* Answer this question “Yes” if the child has siblings under the age of 18 (or over 18 and living in the home) who are receiving Waiver services. Do not list the names of the siblings.
 - *When is an IQ score required?* When the person is applying for the Intellectual Disability Waiver. If the person has a diagnosis of Mental Retardation there should be an IQ score indicated. In instances when there is no IQ score available (e.g. the consumer is a child and too young to test) use the comments field to provide an explanation as to why no IQ score is available and how the determination of Mental Retardation was made.
- **Medical and Physical Issues.** This section is broken down into the subcategories of: Health Conditions, Medication Use, Assistive Devices/Special Equipment, Nutrition, and Daily Living Skills. It also includes assessment of Risk Factors based on each of these areas.
 - **Medication List:** The form provides enough rows for 15 prescription medications and 15 over-the-counter medications. If the consumer is taking more medication, you may need to attach a separate list to the assessment.
 - **FAQs**
 - *How should a question be answered if the consumer's assessment of their health isn't accurate?* Clarify in the comment section if there is a discrepancy between the consumer's rating of their health and that of the assessor.
 - *How specific do I need to be when answering the question: “How frequently did the consumer see his/her medical doctor or specialist in the last year?”* This question is

intended to get an idea about how often the consumer sees their medical doctor, psychiatrist, etc. The answer can be an estimate, such as: “Joe has seen his doctor about 4 times this year, once for a physical, and several other visits for colds and allergies” or “Joe usually sees his psychiatrist once per month for medication adjustments”.

- **Mental Health/Behavioral/Substance Abuse.** This section includes the sub-categories of Emotional and Mental Health; Behavioral; Alcohol/Tobacco/Substance Abuse. This section includes a risk assessment for these areas.
- **Housing and Environment.** This section includes basic questions about the consumer’s current living situation as well as their skill level. It includes assessment of Risk Factors based on Environment Safety and Abuse/Neglect.
 - **FAQs**
 - *How do I answer the questions: “Consumer’s current housing type” and “Consumer’s living arrangement” for persons in an HCBS Waiver Home?* The consumer’s current housing type would be “own home” and their current living arrangement would be “living in a congregate setting”.
- **Social.** This section looks at such things as communication, relationships, and preferred activities. There is no Risk Assessment for this section.
- **Transportation.** This section looks at transportation issues. There is no Risk Assessment for this section.
- **Education.** This section looks at education issues. There is no Risk Assessment for this section.
- **Vocational.** This section looks at vocational and work issues. There is no Risk Assessment for this section.

Risk Assessment Instructions

The Risk Assessment was designed to provide a comprehensive picture of potential safety issues. The results should guide the Crisis Intervention Plan within the Comprehensive Service Plan of each consumer in order to reduce the risk of harm. The overall goal of the Risk Assessment is to decrease risk areas through interventions, resources, and service activities.

The assessment was designed to be completed using the professional judgment of the assessor, rather than asking the questions directly to the consumer or guardian. Professional judgment is required when determining if consumer-specific situations can be helped through intervention. While each of the items within the risk assessment have been identified as predictors of safety issues, individual circumstances of consumers can either elevate or lower the seriousness of each of the predictors.

Questions with “R” in front of the number are risk indicators. A “yes” means there is a potential for harm to the consumer. However, it is possible to have a “yes” on a risk question but specific intervention is not necessary. For example, a consumer may have spent 2 nights in the hospital for removal of appendix. There is nothing that needs to go into the ICP to address this item. Professional judgment comes into play here.

Risk questions are either “yes/no” or “3”, “2”, “1”, “0”. Items that are simply “yes” or “no” tend to be static indicators (meaning they are likely based on historical information that won’t change such as a seizure disorder, an allergy, etc.). Items with the 3 to 0 scoring are dynamic indicators (meaning they are likely to be able to change over time). A score of “3” or “2” is the equivalent of a “yes” and indicates a risk. By varying the scoring in this way, it is possible to measure change for the consumer from year to year. For example, a consumer could move from a 3 to a 2 in an area—while it is still a risk, the consumer has at least reduced the risk and continued intervention could continue to reduce it further.

For consumers who receive 100% of their care from a caretaker (parent, guardian, staff, etc.), score the item based on the quality of that care. For example, even though a consumer may not be independent in hygiene, it would not be a risk if the guardian does it for him (scored as “1” or “0”). However, if the consumer can’t do this and the caretaker does not do it either, then it would be a risk (scored as a “3” or a “2”).

Iowa Department of Human Services
Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)		Medicaid State ID#	Date Of Birth:
Current Address:			
County of Residence:		County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:	
E-mail:			

Assessor

Name:		Title:	
Agency:			
Address:			
Phone:		E-Mail:	
Signature			Date

Type of Assessment

- Initial
- Annual
- Special
- Demographic Change Only
- Discharge

Date: _____ Reason: _____

Basis of Case Management Eligibility

- CMI MR DD BI Waiver Elderly Waiver CMH Waiver Habilitation MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: HCBS Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care	Date
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Case Management Comprehensive Assessment

Consumer Name:

Interdisciplinary team members consulted (including consumer):

Name	Title (if applicable)	Relationship to Consumer

Additional records reviewed:

Consumer Demographics

Gender: Female Male

Language:

	Yes	No
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>
Needs interpreter services	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

Monthly Income: (Please check all that apply)

Source	Amount
<input type="checkbox"/> SSI	\$
<input type="checkbox"/> SSDI	\$
<input type="checkbox"/> Employment	\$
<input type="checkbox"/> Other (specify):	\$
Comments:	

Court Involvement:

<input type="checkbox"/> Involuntary Commitment
<input type="checkbox"/> Probation or Parole
<input type="checkbox"/> Child in Need of Assistance (CINA)
<input type="checkbox"/> Child Protection
<input type="checkbox"/> Delinquency
<input type="checkbox"/> Foster Care
<input type="checkbox"/> Other (Identify)
<input type="checkbox"/> None
Comments:

Case Management Comprehensive Assessment

Consumer Name:

Legal decision maker: (Please check all that apply)

None Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Co-Decision Maker (if applicable):

Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Financial Decision Maker: (e.g. Conservator or Attorney-in-fact) No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Payee: No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)	Relationship:	
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Case Management Comprehensive Assessment

Consumer Name:

Secondary Contact (if applicable):

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section For Adults (Age 18 and Over)

Veteran: Yes No

Marital Status:

- Never Married
 Married
 Divorced
 Legally Separated
 Widowed
 Unknown or Other – Specify

Spouse's Name:

Comments:

Complete This Section For Children (Age 17 and Under)

With whom does the child live?

(If the child currently lives in a institutional setting, please make note in the comments section below.)

What are the child's parent's names?

Parents marital status: Married Divorced Never married

If the parent's are not living together, what is the non-custodial parent's name and address?

Name:

Street:

City, State, Zip:

Parent's contact information (if different from the child's):

Home Phone:

Work Phone:

Cell Phone:

E-Mail:

Are there siblings in the home? Yes No

Are any siblings receiving waiver services? Yes No

Are there any individuals who are not supposed to have contact with the child? Yes No

If yes, specify:

Other Comments:

Case Management Comprehensive Assessment

Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:	
Axis 2:	
Axis 3:	
Axis 4:	
Axis 5:	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Complete this section for consumers applying for or receiving HCBS Intellectual Disability Waiver.

List the most current IQ score, or if the IQ isn't listed, give the consumer's level of functioning within the range of mental retardation (mild, moderate, severe, profound):

IQ:
Range:
Date of Evaluation:

Complete this section for consumers applying for or receiving HCBS Brain Injury Waiver.

Diagnosis:
Date Injury Occurred:

Health Care Provider Information:

Who is your regular doctor? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

Yes (list below) No Don't know

Name	Specialty	Address	Phone

Case Management Comprehensive Assessment

Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

<input type="checkbox"/> Cardiac <input type="checkbox"/> Skin Related <input type="checkbox"/> G.I. Disorders <input type="checkbox"/> Urinary Tract <input type="checkbox"/> Weight problems <input type="checkbox"/> Evidence of communicable disease <input type="checkbox"/> Other – Specify <input type="checkbox"/> None	
How do they affect you and how long have you had them?	
Comments:	

B3. Any respiratory problems that require assistance to manage?

<input type="checkbox"/> Ventilator <input type="checkbox"/> Oxygen <input type="checkbox"/> Suctioning <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Cardiorespiratory monitor <input type="checkbox"/> Chest physiotherapy <input type="checkbox"/> Nebulizer treatment <input type="checkbox"/> Other – Specify <input type="checkbox"/> None	
How do they affect you and how long have you had them?	
Comments:	

B4. Do you regularly receive any of the following medical treatments?

	<input type="checkbox"/> no	<input type="checkbox"/> yes	<i>Days per week</i>	<i>Hours per day</i>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>		
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Supervision for Safety	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes Education	<input type="checkbox"/>	<input type="checkbox"/>		
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory Treatment	<input type="checkbox"/>	<input type="checkbox"/>		
Catheter Care	<input type="checkbox"/>	<input type="checkbox"/>		
Colostomy Care	<input type="checkbox"/>	<input type="checkbox"/>		
Nasogastric Tube Care	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

Case Management Comprehensive Assessment

Consumer Name:

B5. Hearing

- No hearing impairment.
- Hearing impairment, but managed through assistive devices
- Hearing difficulty at level of conversation.
- Hears only very loud sounds.
- No useful hearing.
- Not determined.

Comments:

B6. Vision

- Has no impairment of vision.
- Vision impairment, but managed through assistive devices
- Has difficulty seeing at level of print (far-sighted).
- Has difficulty seeing obstacles in environment (near-sighted).
- Has no useful vision.
- Not determined.

Comments:

B7. Speech/Communication

- Communicates independently or impairment has been compensated to function independently.
- Communicates with difficulty but can be understood.
- Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- No impairment
- Impaired – Specify

Comments:

B9. Cognitive Status

- Alert and fully oriented
- Alert and oriented with significant alteration on self-concept/mood
- Generally oriented through use of assistive techniques
- Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- Exhibits mental status changes consistent with psychiatric disorder
- Comatose, but responsive
- Comatose, but unresponsive
- Other – Specify

Comments:

B10. Musculoskeletal/Fine or Gross Motor Skills

- No Impairment of Musculoskeletal/Fine or Gross Motor Skills
- Impaired muscle tone
- Contractures
- Scoliosis
- Paralysis: Hemiplegia Paraplegia Quadriplegia Other (Specify)

Comments:

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?

Yes (Complete below) No

Name: _____

Relationship: _____

Address: _____

City, State, Zip code: _____

Phone: _____

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?

Yes (Complete below) No

Name: _____

Relationship: _____

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	<input type="checkbox"/>	<input type="checkbox"/>
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	<input type="checkbox"/>	<input type="checkbox"/>
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R10. Is the consumer in need of someone to help if he or she was sick or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	

Case Management Comprehensive Assessment

Consumer Name:

Assistive Devices/Special Equipment

B19. Do you use (or need) any of the following special equipment or aids? None

(If a consumer doesn't have an item but needs it, mark the 'Needs' box)

Uses	Needs		Uses	Needs	
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Hospital bed
<input type="checkbox"/>	<input type="checkbox"/>	Cane	<input type="checkbox"/>	<input type="checkbox"/>	Medical phone alert
<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>	Supplies, e.g. Incontinence pads
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair (manual, electric)	<input type="checkbox"/>	<input type="checkbox"/>	Bedside commode
<input type="checkbox"/>	<input type="checkbox"/>	Brace (leg, back)	<input type="checkbox"/>	<input type="checkbox"/>	Bathing equipment
<input type="checkbox"/>	<input type="checkbox"/>	Helmet	<input type="checkbox"/>	<input type="checkbox"/>	Lift chair
<input type="checkbox"/>	<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	<input type="checkbox"/>	Transfer equipment
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive eating equipment
<input type="checkbox"/>	<input type="checkbox"/>	Glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Harness/gait belt
<input type="checkbox"/>	<input type="checkbox"/>	Weighted blankets or vest	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):

Comments:

ASSISTIVE DEVICES RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R24. Is the consumer in need of assistance with adaptive equipment (need it purchased, need training, need repairs, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R25. Would a power outage interfere with the consumer's necessary adaptive equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan.	No. of risks:			
Comments:				

Nutrition

B20. How is your appetite?

<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Comments:

B21. Has there been an unexplained weight loss or weight gain in the past year?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

B22. Are there health concerns related to your nutrition?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

Case Management Comprehensive Assessment

Consumer Name:

B23. Do you have a diagnosed eating disorder (such as overeating, purging, hoarding food)?

- Yes (specify in comments)
 No

ASSESSOR: If no, does the consumer's behavior indicate a possible eating disorder or suggest the need for further evaluation?

- Yes (specify in comments)
 No

Comments:

B24. Do you have any problems that make it difficult to eat? Yes (complete below) No

- | | |
|--|---|
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Can't eat certain foods |
| <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Problem with gag reflex |
| <input type="checkbox"/> Texture Aversions | <input type="checkbox"/> Sensitive stomach/nausea |
| <input type="checkbox"/> Taste problems | <input type="checkbox"/> Tube feeding (some or all of the time) |
| <input type="checkbox"/> Any other eating problems? (Describe) | |

Comments:

B25. Are you on a special diet: Yes (complete below) No

- | | |
|---|--|
| <input type="checkbox"/> Low salt | <input type="checkbox"/> Calorie supplement |
| <input type="checkbox"/> Low fat | <input type="checkbox"/> Gluten Free |
| <input type="checkbox"/> Low sugar | <input type="checkbox"/> Milk/lactose free |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Altered Consistency |
| <input type="checkbox"/> Other special diet? (Describe) | |

Comments:

NUTRITION RISK FACTORS	YES		NO	
	3	2	1	0
<small>3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never</small>				
R26. Is the consumer at risk of choking or other problems when eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R27. Is the consumer's health at risk due to poor nutrition (e.g.- eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R28. Is the consumer (or the caretaker) ever non-compliant with the prescribed diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R29. Would the consumer's health be at risk if his or her diet is not strictly followed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Daily Living Skills

B26. Daily Living Skills

Activity	Independent	Supervision or Verbal Prompts/Cueing	Physical Assistance	Total Dependence	Frequency	
					Daily	Intermittent
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Grooming & personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mobility in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Mobility with wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (note use of assistive devices or adaptive equipment needed to demonstrate skill):

B27. Toilet Use

<input type="checkbox"/> Continent – Bowel and bladder <input type="checkbox"/> Continent with verbal or physical prompts <input type="checkbox"/> Continent except for specified periods of time (e.g. enuresis) <input type="checkbox"/> Incontinent – bladder <input type="checkbox"/> Incontinent – bowel <input type="checkbox"/> Catheter or -ostomy (e.g. suprapubic catheter, colostomy, ileostomy) <input type="checkbox"/> Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)
Comments:

DAILY LIVING SKILLS RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R30. Is the consumer's health at risk due to poor hygiene?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R31. Is the consumer at risk for falling? In the past year has the consumer fractured a bone? If yes, how did this occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R32. Is the consumer at risk of being dropped or injured during transfer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Medical and Physical Health
<p>What are your strengths and abilities related to your medical and physical health?</p> <p>ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your medical and physical health that haven't been addressed above?</p> <p>ASSESSOR: List any other needs related to medical and physical health not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your medical and physical health?</p> <p>What are your desired results related to your medical and physical health?</p>

Case Management Comprehensive Assessment

Section C: Mental Health, Behavioral & Substance Use

Emotional and Mental Health

C1. Have you ever been diagnosed with a mental illness?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is it?

C2. Have you received mental health services in the past?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:

C3. Are you currently receiving any mental health services or counseling?

<input type="checkbox"/> Yes (If yes, complete below) <input type="checkbox"/> No	
Provider Name and Address	Comments

C4. Emotional Assessment. How have you been feeling during the past month?

	Yes	No
Are you satisfied with your life today?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been depressed or very unhappy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been feeling like you have too much energy or can't stop being busy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had mood swings?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt unmotivated or felt a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt lonely or isolated?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

C5. ASSESSOR: Other mental health symptoms.

	Yes	No
Has the consumer had hallucinations (seen or heard things that weren't really there)?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer reported feelings of paranoia?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer had delusions (irrational thoughts that weren't true)?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Children (Age 17 and Under)

C6. Has the child experienced difficulty in interpersonal relationships within the family?

Yes No

Comments: _____

C7. Does the parent/guardian exhibit mental health related concerns?

Yes No

If yes, is he/she currently receiving treatment and following through with treatment?

Yes No

Comments: _____

Behavioral

C8. ASSESSOR: Behavioral Assessment.

Behavioral Issue	Does not exhibit	Has been modified to socially acceptable levels	May require verbal or physical intervention
Has episodes of disorientation, being withdrawn, or similar behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noncompliance with rules or directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abusive to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits disruptive behavior (e.g. arguing, shouting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits destructive behavior (e.g. destroying property, burning, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits stereotypical, repetitive behavior (e.g. rocking, twirling fingers or objects, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/compulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antisocial behavior (e.g. lying, stealing, inappropriate touching, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wanders into private areas, or habitually elopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acts in a sexually inappropriate or aggressive manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engages in excessive liquid consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____			

Alcohol/Tobacco/Substance Use

C9. Do you drink any alcoholic beverages?

Yes

No

If yes, on average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?

Comments: _____

C10. Do you smoke or use tobacco?

Yes

No

If yes, how much and how often? (frequency per day)

Comments: _____

C11. Has tobacco use caused you any problems?

Yes

No

If yes, please describe:

Comments: _____

Case Management Comprehensive Assessment

Consumer Name:

C12. Do you use any other illegal substances such as marijuana, cocaine, or amphetamines?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify:
Comments:

C13. Are the people who are involved in your life (spouse, parents/guardian, friends, etc.) concerned about your alcohol/tobacco/substance use?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain:
Comments:

C14. Do you live with or spend time with a person that has alcohol/substance abuse concerns, including misuse of prescription medication? (For children, this includes the parent/guardian)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify:
Comments:

C15. **ASSESSOR:** Does the person need education about substance use/abuse?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:
Comments:

C16. **ASSESSOR:** Are you concerned about the person's alcohol/tobacco/substance use?

<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS	YES		NO	
	3	2	1	0
3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never				
R33. Has the consumer ingested foreign objects or been diagnosed with PICA?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R34. Has alcohol use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R35. Has substance use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R36. Has the consumer engaged in self-injurious behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R37. Has the consumer left or attempted to leave home or other supervised activities without permission, or when it would be unsafe to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R38. Has the consumer been aggressive toward others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R39. Has the consumer used weapons or objects to hurt self or others? (If 3 or 2, assure that referral has been made to a qualified mental health professional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R40. Has the consumer threatened suicide or made suicidal gestures? (If 3 or 2, assure that referral has been made to a qualified mental health professional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Case Management Comprehensive Assessment

Consumer Name:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS <small>3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never</small>	YES		NO	
	3	2	1	0
R41. Has the consumer attempted suicide? (If 3 or 2, assure that referral has been made to a qualified mental health professional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R42. Has the consumer engaged in criminal behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R43. Has the consumer had a significant life change or event occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R44. Does the consumer have a history of other life-threatening behaviors? Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

C17. **ASSESSOR:** In your opinion would this person benefit from a:

<input type="checkbox"/> Mental health referral
<input type="checkbox"/> Mental health evaluation
<input type="checkbox"/> Substance abuse referral
<input type="checkbox"/> Substance abuse evaluation
<input type="checkbox"/> Referral for a behavioral assessment
<input type="checkbox"/> Other (specify):
<input type="checkbox"/> None
Comments:

Consumer Needs, Wants, and Desired Results Related to Mental Health, Behavior, or Substance Abuse
What are your strengths and abilities related to mental health, behavior, or substance abuse? ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to mental health, behavior, or substance abuse that haven't been addressed above? ASSESSOR: List any other needs related to mental health, behavior, or substance abuse not mentioned by the consumer or guardian. Do you have any wants related to mental health, behavior, or substance abuse? What are your desired results related to mental health, behavior, or substance abuse?

Case Management Comprehensive Assessment

Section D: Housing and Environment

D1. What is your current housing type?

- Own Home (includes parent/guardian's home for children)
- Friend/Relative Home
- Foster Care
- RB-SCL
- RCF
- RCF-PMI
- RCF-MR
- ICF-MR
- ICF/Nursing Facility
- MHI
- Skilled Nursing Facility
- Homeless
- Jail
- Other (specify):

Comments:

D2. What is your current living arrangement?

- Living Alone
- Living with Family/Friend
- Living with Spouse/Significant Other
- Living with Parents
- Living in Congregate Setting
- Other (specify):

Comments:

D3. Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

- Continue to live here
- Don't know
- Prefer to live elsewhere (Specify and briefly describe the barriers, if any:)

Comments:

D4. Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

- Yes
- No

If yes, how often?

Caregiver's Name:

D5. Do you have any home modifications? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Safe Room | <input type="checkbox"/> Shatter Proof Windows |
| <input type="checkbox"/> Door/Window Alarms | <input type="checkbox"/> Fenced yard |
| <input type="checkbox"/> Wheelchair Ramp | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (specify): | |

Are any home modifications needed?

- Yes (specify):
- No

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Children (Age 17 and Under)

(If the child is currently living in a institutional setting, skip questions D6 through D9 and not the living situation in the comment section below.)

D6. Does the family with whom the child is residing have a stable housing situation? Yes No
If not, does the family need assistance in identifying additional resources?

D7. Does the parent/guardian have a physical disability that impairs his/her ability to meet the child's needs? Yes No
If yes, what have the parents done to ensure the child's needs are being met consistently?

D8. Does the family have adequate financial resources? Yes No
If not, does the family need assistance in identifying additional resources?

D9. Does the child have his or her own money? Yes No
Where does it come from?

Other Comments: _____

Independent Living Skills

D10. How well can you prepare meals for yourself? (Meals may include sandwiches, pre-cooked meals and TV dinners.)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments: _____

D11. Do you know your telephone number?

- | | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|

D12. Do you know your address?

- | | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|

D13. **ASSESSOR:** Can this consumer be left without supervision?

- | | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|

If yes, for how long? _____

D14. How well are you able to answer the telephone?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments: _____

D15. How well are you able to make a telephone call?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments: _____

Case Management Comprehensive Assessment

Consumer Name:

D16. How well can you handle your own money? (understands use of money, can pay for things, can pay bills, can balance the checkbook, etc. as appropriate for age)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D17. How well can you manage shopping for food and other things you need?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

Complete This Section For Adults (Age 18 and Over)

D18. How well can you manage to do light housekeeping, like dusting or sweeping?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D19. How well can you do heavy housekeeping, like yard work, or emptying the garbage?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D20. How well can you do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D21. **ASSESSOR:** Does the consumer have deficits that pose a threat to his/her ability to live in the community?

- Yes
- No
- Unsure

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Children (Age 17 and Under)

D22. Does the child do chores? Yes No
If yes, what are they?

How independent is the child in completing chores?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

HOUSING AND ENVIRONMENTAL SAFETY RISK FACTORS	Yes	No		
R45. Would this consumer's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	<input type="checkbox"/>	<input type="checkbox"/>		
R46. Is the consumer at risk at home because of any of these conditions:				
structural damage	<input type="checkbox"/>	<input type="checkbox"/>		
barriers to accessibility (steps, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		
electrical hazards	<input type="checkbox"/>	<input type="checkbox"/>		
signs of careless smoking	<input type="checkbox"/>	<input type="checkbox"/>		
insects or pests	<input type="checkbox"/>	<input type="checkbox"/>		
poor lighting	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient water or no hot water	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient heat	<input type="checkbox"/>	<input type="checkbox"/>		
fire hazards	<input type="checkbox"/>	<input type="checkbox"/>		
tripping hazards	<input type="checkbox"/>	<input type="checkbox"/>		
unsanitary conditions	<input type="checkbox"/>	<input type="checkbox"/>		
R47. Does the consumer need to be supervised at all times?	<input type="checkbox"/>	<input type="checkbox"/>		
R48. Is the consumer without means of communication (no phone or PERS)?	<input type="checkbox"/>	<input type="checkbox"/>		
For the following items use: 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
	3	2	1	0
R49. Is the consumer unable to respond to emergencies independently? If consumer is never left alone, mark not applicable: <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R50. Is the consumer physically stronger than any of his/her caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R51. Does the consumer lack awareness of dangerous/emergency situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R52. Does the consumer put him/herself in danger due to careless or risky behaviors (careless smoking, leaving doors unlocked, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R53. Is the consumer isolated (lack of transportation, lack of social network)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R54. Is the consumer's neighborhood unsafe (high risk of crime, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R55. Is the consumer at risk in the community due to unsafe behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Abuse/Neglect

D23. **ASSESSOR:** Does the consumer have a history of incidents that have resulted in injury or threat of injury in the past year?
(Consult incident reports as necessary)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are the causes of the incidents covered in the Crisis Intervention Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify why not):

ABUSE/NEGLECT RISK FACTORS	YES		NO	
	3	2	1	0
3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never				
R56. Has the consumer been physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R57. Has the consumer been sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R58. Has the consumer been emotionally or psychologically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R59. Is there evidence of neglect to the consumer by a caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R60. Is there evidence of neglect by the consumer (self neglect)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R61. Has the consumer been denied basic necessities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R62. Has the consumer witnessed abuse or neglect of another person, including domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R63. Would the consumer be an "easy target"?	<input type="checkbox"/>		<input type="checkbox"/>	
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Needs, Wants, and Desired Results Related to Housing and Environment
<p>What are your strengths and abilities related to your housing and environment?</p> <p>ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your housing and environment that haven't been addressed above?</p> <p>ASSESSOR: List any other needs related to housing and environment not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your housing and environment?</p> <p>What are your desired results related to your housing and environment?</p>

Case Management Comprehensive Assessment

Section E: Social

E1. Do you feel you need help with social skills?

- Yes
 No

Comments:

E2. What is a typical day like for you? (or ask: What do you usually do, starting from the morning?)

What, if anything, would you change about your typical day?

Comments:

E3. What activities or things do you enjoy doing?

Are there activities you enjoy that you would like to do more frequently?

- Yes
 No

If yes, what are they?

Is anything needed to support or help you to do these activities?

- Yes
 No

If yes, what?

Comments:

E4. If you choose to practice a religion, are able to attend as often as desired?

- Yes (Specify where):
 No
 N/A

Comments:

E5. **ASSESSOR:** Does the consumer have knowledge or self-concept of his or her own sexuality appropriate to age level?

- Yes
 No

Comments:

E6. Do you communicate with friends, relatives, or others (not including paid helpers) as often as you would want?

- Yes
 No

By what means (phone, email, etc)? How Often?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

E7. Do you spend time with others who do not live with you as often as you would want?

Yes No

Comments:

E8. Do you have someone to confide in when you have a problem?

Yes No

If yes, specify name and relationship:

Complete This Section For Children (Age 17 and Under)

E9. Who are your friends?

E10. What do you like to do with them?

E11. Where do you see your friends?

E12. Do you and your parents agree on your choice of friends?

Yes No

If no, why not?

Consumer Needs, Wants, and Desired Results Related to Social Functioning

What are your strengths and abilities related to your social functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your social functioning that haven't been addressed above?

ASSESSOR: List any other needs related to social functioning not mentioned by the consumer or guardian.

Do you have any wants related to your social functioning?

What are your desired results related to your social functioning?

Case Management Comprehensive Assessment

Section F: Transportation

F1. Do you need help with transportation?

- Yes
 No

If yes, when and where:

F2. How do you get to the places you want to go? (Check all that apply).

- Walk
 Bicycle
 Drive
 Take a bus or taxi
 Friend or family member drives
 Staff/Provider
 Other:

Comments:

F3. How well are you able to use public transportation or drive to places beyond walking distance?

- Need no help or supervision
 Need some help or occasional supervision
 Need a lot of help or constant supervision
 Not Available
 Can't do it at all

Comments:

F4. Are there any vehicle modifications needed?

- Yes
 No

If yes, specify:

Comments:

Consumer Needs, Wants, and Desired Results Related to Transportation

What are your strengths and abilities related to transportation?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to transportation that haven't been addressed above?

ASSESSOR: List any other needs related to transportation not mentioned by the consumer or guardian.

Do you have any wants related to transportation?

What are your desired results related to transportation?

Case Management Comprehensive Assessment

Section G: Education

G1. Are you currently in school?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify where: If no, and the consumer is a child, why not?
Comments:

G2. If in school, are you involved in any extra-curricular activities?

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, specify:
Comments:

G3. **ASSESSOR:** Is the consumer able to:

	Yes	No	Comments
Read?	<input type="checkbox"/>	<input type="checkbox"/>	
Write?	<input type="checkbox"/>	<input type="checkbox"/>	
Sign his/her name?	<input type="checkbox"/>	<input type="checkbox"/>	

G4. Are you interested in furthering your education?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what area do you want to further your education in?
Comments:

G5. Do you need assistance or support in gaining access to educational services?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify what type of assistance is needed:
Comments:

G6. **ASSESSOR:** Does the consumer have any intellectual or cognitive difficulties?

<input type="checkbox"/> No intellectual problems
<input type="checkbox"/> Has difficulties but is able to function with minimal assistance or adaptive devices
<input type="checkbox"/> Has intellectual problems requiring verbal or physical assistance (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty with or unable to tell time <input type="checkbox"/> Does not know survival words or signs <input type="checkbox"/> Problems with reading <input type="checkbox"/> Problems with writing <input type="checkbox"/> Difficulty with number skills <input type="checkbox"/> Difficulty with reasoning and problem solving <input type="checkbox"/> Memory problems <input type="checkbox"/> Other – specify

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

G7. What is the highest level of education you have completed?

- | | |
|--|---|
| <input type="checkbox"/> Less than High School | <input type="checkbox"/> Trade School |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Some College |
| <input type="checkbox"/> GED | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Graduated Special Education | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Unknown |

Comments:

Complete This Section For Children (Age 17 and Under)

G8. What grade are you in? N/A

G9. Do you like school?

- Yes
 No
 N/A

If no, why not?

G10. **ASSESSOR:** Is the child following the school's attendance policy?

- Yes
 No
 N/A

If no, what are the circumstances?

G11. **ASSESSOR:** Does the child have a Special Education Plan?

- Yes (specify): IEP 504 Plan
 No
 N/A

G12. **ASSESSOR:** Is there an aide or mentor assigned to the child?

- Yes
 No
 N/A

G13. **ASSESSOR:** Is the child on target to graduate with his or her class?

- Yes
 No
 N/A

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Education
<p>What are your strengths and abilities related to education?</p> <p>ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to education that haven't been addressed above?</p> <p>ASSESSOR: List any other needs related to education not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to education?</p> <p>What are your desired results related to education?</p>

Case Management Comprehensive Assessment

Section H: Vocational

Complete this section for consumers age 14 or older.

H1. Do you work?

- Yes
 No
 N/A

Comments:

Questions for consumers who are currently working:

H2. What is your current work setting?

	Where Employed:
<input type="checkbox"/> Competitive employment: full-time	
<input type="checkbox"/> Competitive employment: part-time	
<input type="checkbox"/> Supported Employment	
<input type="checkbox"/> Enclave	
<input type="checkbox"/> Sheltered work	

If competitively employed, do you use natural supports in the work environment? Yes No

Comments:

H3. Are you happy in your current job?

- Yes
 No

If no, what job would you like to do?
Why does this job appeal to you?

Comments:

Questions for consumers who are not currently working:

H4. Are you able to work in the community?

- Yes
 No

Comments:

H5. Do you want to work in the community?

- Yes
 No

If yes what job would you like to do?
Why does this job appeal to you?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Question for consumers who are working, or who are not working but are willing and able to work:

H6. Do you need help in any of the following areas?

	Yes	No
Looking for and obtaining a job	<input type="checkbox"/>	<input type="checkbox"/>
Job interviewing	<input type="checkbox"/>	<input type="checkbox"/>
Attending work as scheduled	<input type="checkbox"/>	<input type="checkbox"/>
Arriving to work on time and returning to work after lunch and breaks	<input type="checkbox"/>	<input type="checkbox"/>
Being appropriately dressed and groomed for work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting work assignments and completing them according to instructions	<input type="checkbox"/>	<input type="checkbox"/>
Independently initiating work	<input type="checkbox"/>	<input type="checkbox"/>
Attending to work tasks without distraction	<input type="checkbox"/>	<input type="checkbox"/>
Following written directions	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 1-step task	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 2-3 step task	<input type="checkbox"/>	<input type="checkbox"/>
Communicating wants or needs	<input type="checkbox"/>	<input type="checkbox"/>
Timely informing employer when going to miss work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting changes in schedule or routine	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with co-workers	<input type="checkbox"/>	<input type="checkbox"/>
Other, including any barriers to obtaining employment:		
Comments:		

Consumer Needs, Wants, and Desired Results Related to Vocational Functioning
<p>What are your strengths and abilities related to your vocational functioning?</p> <p>ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your vocational functioning that haven't been addressed above?</p> <p>ASSESSOR: List any other needs related to vocational functioning not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your vocational functioning?</p> <p>What are your desired results related to your vocational functioning?</p>