

## 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/ID:

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/ID:

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/ID:

- 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/ID 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 injectible) 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/ID:

- |   |  |
|---|--|
| <input type="checkbox"/> Adult Attendant Care Services        | <input type="checkbox"/> Adult Companion Services      |
| <input type="checkbox"/> Adult Day Health Care                | <input type="checkbox"/> Adult Day Health Care Nursing |
| <input type="checkbox"/> Adult Day Health Care Transportation | <input type="checkbox"/> Adult Dental Services         |

- Adult Vision
- Behavior Support Services
- Community Services
- Employment Services
- Nursing Services
- Personal Care II
- Prescribed Drugs
- Psychological Services
- Respite Care
- Support Center Services
- Audiology Services
- Career Preparation Services
- Day Activity
- Environmental Modifications
- Personal Care I
- Personal Emergency Response System (PERS)
- Private Vehicle Modifications
- Residential Habilitation
- Specialized Medical Equipment, Supplies and Assistive Technology

Evaluator (Participating ID Team Members)	Title