

## Consumer Profile

**Please note:** This form is to be used as an aid for the provider to quickly assess the individual's needs. This provides a brief description of the individual's support needs. The consumer Profile form in no way replaces the Individual Support Plan or any additional information that is required for the providers to determine if they can support the individual successfully.

<b>Person Completing Profile and Title:</b>	<b>Date Profile Completed:</b>
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### Consumer Identification

Consumer Name:	Date of Birth:	Client ID (Statewide ID):
Financial Resources: Source:	Amount: \$	Spend down amount: \$
Diagnosis (list name of diagnosis not just the number)		
Axis I-		
Axis II-		
Axis III-		

### County Preference

1 <sup>st</sup> Choice:	2 <sup>nd</sup> Choice:
3 <sup>rd</sup> Choice:	Statewide: <input type="checkbox"/>

### About the Consumer

Day Activities & Services		Full Time	Part Time		Daily Living Needs (All That Apply)				
Activity / Service				Support Needed:	None	Minimal	Moderate	Extensive	
<input type="checkbox"/> Day Habilitation		<input type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Vocational Training		<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> School		<input type="checkbox"/>	<input type="checkbox"/>	Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/>	<input type="checkbox"/>	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Speech Therapy		<input type="checkbox"/>	<input type="checkbox"/>	Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/>	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Competitive Employment		<input type="checkbox"/>	<input type="checkbox"/>	Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Supported Employment		<input type="checkbox"/>	<input type="checkbox"/>	Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sheltered Employment		<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/> Volunteer		<input type="checkbox"/>	<input type="checkbox"/>						

Medical Support Needs (All That Apply)	
<input type="checkbox"/> Allergy(s) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bowel Care <input type="checkbox"/> Braces <input type="checkbox"/> Catheterization <input type="checkbox"/> Communicates with Sign Language <input type="checkbox"/> Colostomy <input type="checkbox"/> Dentures <input type="checkbox"/> Diabetes, Insulin Dependent <input type="checkbox"/> Diabetes, Non-Insulin Dependent <input type="checkbox"/> Dialysis <input type="checkbox"/> Accessible environment <input type="checkbox"/> Accessible transportation <input type="checkbox"/> Hearing - Deaf <input type="checkbox"/> Hearing - Hearing Aids <input type="checkbox"/> Hearing - Normal <input type="checkbox"/> Hearing - Partial hearing loss <input type="checkbox"/> Hearing - Unknown or undetermined hearing capabilities <input type="checkbox"/> Illnesses that interfere with daily routine <input type="checkbox"/> Illnesses that require medical attention <input type="checkbox"/> Incontinence <input type="checkbox"/> Mobility - Crawls <input type="checkbox"/> Mobility - Electric wheelchair independently <input type="checkbox"/> Mobility - Electric wheelchair with transfer assist <input type="checkbox"/> Mobility - Lift <input type="checkbox"/> Mobility - Manual wheelchair with assistance <input type="checkbox"/> Mobility - Manual wheelchair with transfer assistance <input type="checkbox"/> Mobility - Manual wheelchair without assistance <input type="checkbox"/> Mobility - Requires total assistance with mobility	<input type="checkbox"/> Mobility - Walker/Cane <input type="checkbox"/> Mobility - Walks independently <input type="checkbox"/> Mobility - Walks unaided with difficulty <input type="checkbox"/> Mobility - Walks with supportive devices <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Seizures <input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Special Diet Preparation <input type="checkbox"/> Speech - Communicates using assisted devices <input type="checkbox"/> Speech - Communicates using gestures or eye pointing <input type="checkbox"/> Speech - Communicates using sign language <input type="checkbox"/> Speech - Difficult to understand <input type="checkbox"/> Speech - No functional communication <input type="checkbox"/> Speech - Normal <input type="checkbox"/> Suctioning <input type="checkbox"/> Therapeutic Positioning <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Uncontrolled seizures <input type="checkbox"/> Ventilator <input type="checkbox"/> Vision - Blind <input type="checkbox"/> Vision - Impaired but corrected with glasses <input type="checkbox"/> Vision - Impaired vision <input type="checkbox"/> Vision - No functional vision <input type="checkbox"/> Vision - Normal <input type="checkbox"/> Vision - Travel vision but legally blind <input type="checkbox"/> Vision - Unknown or undetermined visual ability <input type="checkbox"/> Wears Depends

**Altered Levels of Supervision Needed** (All That Apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Requires RN/LPN oversight on all shifts | <input type="checkbox"/> Max Time Alone – Less Than 1 Hour     |
| <input type="checkbox"/> 24 Hour                                 | <input type="checkbox"/> Max Time Alone – 10+ Hours            |
| <input type="checkbox"/> Moderate Supervision                    | <input type="checkbox"/> Unable to Evacuate Without Assistance |
| <input type="checkbox"/> Line of Sight                           | <input type="checkbox"/> Max Time Alone – 1-3 Hours            |
| <input type="checkbox"/> Awake, Overnight Staff                  | <input type="checkbox"/> Max Time Alone – 3-10 Hours           |
| <input type="checkbox"/> Constant Supervision                    | <input type="checkbox"/> 1:1 Staffing                          |
| <input type="checkbox"/> Max Time Alone – Less Than 15 Minutes   | <input type="checkbox"/> More than 1:1 Staffing                |

**Behavioral Issues** (All That Apply)

- | Monitoring Needed        | Protection Needed        |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical Abuse                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Dishonesty                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Elopement                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical Aggression                      |
| <input type="checkbox"/> | <input type="checkbox"/> | PICA                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Property Destruction                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Self-Abuse                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexuality - Vulnerability                |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexuality (Predator - Preference Female) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexuality (Predator - Preference Male)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexuality (Predator - Children)          |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Interactions                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Extra Support for Transportation         |
| <input type="checkbox"/> | <input type="checkbox"/> | Verbal Aggression                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Stealing                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Fire Setting                             |

**Family Involvement** (Check Only One)

- Frequent  
 Infrequent  
 None

**Guardianship:**

- Name:**  
 Limited     Full

**Payee:**

**Sexually Aberrant Behavior**

(defined as inappropriate sexual behavior that puts the individual or others at risk of physical or psychological harm and/or causes high level of concern within the community. Examples: criminal sexual behaviors, non-consensual sexual acts, predatory behaviors etc.)

- Yes     No

**Intellectual Skills** (All That Apply)

**Support Needed (None, Minimal, Moderate, Extensive):**

None	Min.	Mod.	Ext.		None	Min.	Mod.	Ext.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coping Skills: Does not handle everyday stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment Impaired: Rational Decisions Health
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coping Skills: Dislikes disruptions in environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment Impaired: Rational Decisions Financial
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment Impaired: Easily Taken Advantage Of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment Impaired: Rational Decisions Safety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment Impaired: Inability to Advocate for Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognize Reality: Paranoia or Delusional Behavior

**Rights Restriction:**

**Brief description of unique or special support needs:**

**Summary of Current Situation:**

Attach – Plan, BSP, Last Nursing Review/HIPS

<b>Information for Determining Rate</b>	
<b>Support Intensity Scale/Vineland Index</b> <i>(for shared living only):</i>	<b>Check if:</b> <input type="checkbox"/> New Placement <input type="checkbox"/> Move from Current Placement
<b>Rate Allocation Score</b> <i>(for group home):</i>	
<b>ISL Rate:</b>	