The answers on this form should reflect how much support or assistance the person needs or requires, either for the management of a behavioral or health condition or to complete a task or activity. This may not be the same as how much support or assistance the person is currently receiving. Unless specifically asked to do otherwise, consider the past 3 to 6 months when answering the questions. Please check only one box per item, unless specifically asked to do otherwise.

After identifying the type of support need for each item, please identify if there is an unmet need placing the person at risk of illness, injury or harm.

Please skip the following four sections if the individual is under the age of **seven**: Daily Living Supports, Personal Care Supports, Safety, and Unusual Behavioral Supports.

PLEASE CHECK YES FOR ANY CRITICAL SERVICE SITUATION; OTHERWISE, CHECK NO.

Critical Service Situation	No ✓	Yes ✓
a. Young adult aging out of Lopez or Autism Waiver and needs the same level of care to maintain well-being	☐	☐
b. Olmstead issue	☐	☐
c. Is the focus of a court order or imminent court order	☐	☐
d. The person is under age 18 and requires coordinated services through several agencies to avoid court action	☐	☐
e. The person is in the care and custody of DSS Children's Division, which has a formal agreement in place with a division regional office (when formal agreement is ending)	☐	☐
f. Requires immediate life-sustaining intervention to prevent an unplanned hospitalization or residential placement	☐	☐
g. Person needs immediate services in order to protect self, another person(s) from immediate harm.	☐	☐

State page and paragraph in service plan where this is documented:

CHECK THE ONE BOX WHICH BEST DESCRIBES HOW MUCH SUPPORT THE PERSON TYPICALLY REQUIRES TO DO EACH DAILY LIVING ACTIVITY. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Daily Living Supports		✓	Unmet Need ✓
1. Mobility in the Community – Includes the ability to move around outside and in the community (Does not include any transportation needs). *please refer to the manual if the person is wheelchair dependent*	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
2. Taking Medications – Includes taking the correct medication, accurate dose, and proper consistency (e.g., crushed) at the correct time or filling pillbox if used. Includes monitoring glucose level if needed.	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
3. Using the Telephone – Includes dialing the number and/or communication over the phone	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
4. Doing Household Chores – Includes housecleaning, laundry, etc.	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
5. Shopping and Meal Planning – Includes planning for meals and shopping for groceries or other goods in neighborhood area.	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
6. Meal Preparation and Cooking – Includes getting the food out of the cupboard or refrigerator, preparing food (including making food into appropriate consistency such as ground up, specified piece size, pureed, or liquefied), making cold meals (such as sandwiches or snacks), and cooking simple meals.	Independent		☐
	Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		

What page and paragraph can a detailed description of unmet need be found in the service plan?

CHECK THE ONE BOX WHICH BEST DESCRIBES HOW MUCH SUPPORT THE PERSON TYPICALLY REQUIRES TO DO EACH PERSONAL CARE ACTIVITY. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Personal Care Supports		✓	Unmet Need ✓
7. Dressing and Undressing – Includes ability to take clothes out of drawers, choose weather appropriate clothes, and use of fasteners.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
8. Bathing or Showering – Includes sponge bath, tub bath or shower and water temperature regulation.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
9. Grooming and Personal Care – Includes brushing teeth or hair, shaving or applying deodorant.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
10. Using the Toilet – Includes going to the bathroom for bowel and urine elimination, wiping self, menstruation care, incontinent care, and ostomy/catheter care.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on Assistance		
	Total hands-on assistance		
11. Eating (includes IV, NG, G, or J tube feeding) – Includes ability to use fork or spoon from plate to mouth and to cut food. Does not include chewing and swallowing (covered below).	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
12. Changing Position in Bed – Includes ability to turn side to side. Does not include ability to get out of bed or chair.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
13. Chewing and Swallowing – Includes ability to chew food and swallow food without choking.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
14. Mobility in the Home – Includes the ability to move around inside the home or residence. *please refer to the manual if the person is wheelchair dependent*	Independent		☐
	Partial Assistance/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		
15. Transferring – Includes ability to move from bed to a chair or to a wheelchair.	Independent		☐
	Verbal Prompting/Monitoring		
	Partial hands-on assistance		
	Total hands-on assistance		

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

PLEASE CHECK THE ONE BOX WHICH BEST DESCRIBES SAFETY SUPPORTS. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Safety Supports	No ✓	Yes ✓	Unmet Need ✓
16. The person responds appropriately without prompting to basic safety issues at home – for example, evacuating the residence if there is a fire.	☐	☐	☐
17. Overall, the person usually makes safe choices when at home – for example, not putting metal in a microwave or toaster, not opening the door to strangers or locking the door at night.	☐	☐	☐
18. The person always requires 2 people for transferring, fire evacuation, or positioning.	☐	☐	☐
19. The person is able to obtain necessary emergency assistance by some means – for example, dialing 911, pressing an emergency button, getting help from a neighbor, etc.	☐	☐	☐
20. The person responds appropriately to safety issues when not at home – for example, evacuating building appropriately if fire alarm goes off, staying on the sidewalk or refusing a ride from a stranger.	☐	☐	☐
21. The person is able to avoid being taken advantage of financially – for example, not giving his/her money to strangers, or not giving out personal financial or social security information to strangers.	☐	☐	☐
22. The person is able to avoid being taken advantage of sexually or is able to avoid sexual exploitation, including when at home, in the community, or with strangers.	☐	☐	☐

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

Support Required	Support Frequency
• No Support Needed=No support needed or can ignore behavior. • Monitor=Monitor only using a person or through environmental means. Includes monitoring for behaviors addressed by medications or treatment plan. • Verbal Redirection=Verbal or gestural redirection or prompting typically needed. • Hands-on Support=One person hands-on support typically needed to redirect or support person.	• Episodic=Episodic, or seasonal only • Less Monthly=Less than monthly • Monthly=Monthly • Weekly=Weekly • Daily=Once a day or more

PLEASE CHECK YES FOR ANY BEHAVIORS SUPPORTED OR JUSTIFIED IN THE SERVICE PLAN ACTION STEPS IN THE PAST 12 MONTHS; OTHERWISE, CHECK NO. THEN FILL IN THE CODES FOR THE TYPE AND FREQUENCY OF SUPPORT TYPICALLY NEEDED DURING WAKING HOURS FOR EACH BEHAVIOR. TREATMENT PLANS WITH ACTION STEPS INCLUDE STRATEGIES TO: 1) CHANGE A BEHAVIOR; 2) REPLACE A BEHAVIOR; 3) ADDRESS A BEHAVIOR THROUGH SUPPORT STRATEGIES. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Behavioral Supports I	No ✓	Yes ✓	Support	✓	Frequency	✓	Unmet Need ✓
23. Bolting (Suddenly running or darting away--excludes wandering away).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
24. Eating or drinking nonfood item (pica) (Includes ingestion of items or liquids not meant for food, such as paper clips, coins, detergent, dirt, cleaning solutions, etc.).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
25. Impulsive food or liquid ingestion (Includes binge eating or compulsive, rapid ingestion of large quantities of food or liquid).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
26. Intentional property destruction.	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
27. Self-injurious behavior (Includes any behavior which harms one's physical self, such as head banging, biting/ hitting self, skin picking, scratching self, etc.).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
28. Severe physical assault or aggression (Can cause injury such as biting, or punching, or attacking).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands on Support		Weekly		
					Daily		

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

Support Required	Support Frequency
• No Support Needed=No support needed or can ignore behavior. • Monitor=Monitor only using a person or through environmental means. Includes monitoring for behaviors addressed by medications or treatment plan. • Verbal Redirection=Verbal or gestural Redirection or prompting typically needed. • Hands-on Support=One person hands-on support typically needed to redirect or support person.	• Episodic=Episodic, or seasonal only • Less Monthly=Less than monthly • Monthly=Monthly • Weekly=Weekly • Daily=Once a day or more

PLEASE CHECK YES FOR ANY BEHAVIORS SUPPORTED OR JUSTIFIED IN THE SERVICE PLAN WITH ACTION STEPS IN THE PAST 12 MONTHS; OTHERWISE, CHECK NO. THEN FILL IN THE CODES FOR THE TYPE AND FREQUENCY OF SUPPORT TYPICALLY NEEDED DURING WAKING HOURS FOR EACH BEHAVIOR. TREATMENT PLANS WITH ACTION STEPS INCLUDE STRATEGIES TO: 1) CHANGE A BEHAVIOR; 2) REPLACE A BEHAVIOR; 3) ADDRESS A BEHAVIOR THROUGH SUPPORT STRATEGIES. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Behavioral Supports II	No ✓	Yes ✓	Support	✓	Frequency	✓	Unmet Need ✓
29. Disruptive behaviors, not aggression (Includes any behavior which disrupts or interferes with activities of the person or others).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
30. Mild physical assault, aggression or theft (Does not cause injury, such as pushing, grabbing, or spitting).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
31. Opposes support or assistance that places the individual at risk of illness, injury or harm (Includes resisting care or assistance).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
32. Verbal aggression or emotional outbursts (Includes verbal threats, name calling, verbal outbursts, and temper tantrums).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
33. Wandering away (Excludes bolting).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

Support Required	Support Frequency
• No Support Needed=No support needed or can ignore behavior. • Monitor=Monitor only using a person or through environmental means. Includes monitoring for behaviors addressed by medications or treatment plan. • Verbal Redirection=Verbal or gestural Redirection or prompting typically needed. • Hands-on Support=One person hands-on support typically needed to redirect or support person.	• Episodic=Episodic, or seasonal only • Less Monthly=Less than monthly • Monthly=Monthly • Weekly=Weekly • Daily=Once a day or more

PLEASE CHECK YES FOR ANY UNUSUAL BEHAVIORS SUPPORTED OR JUSTIFIED IN THE SERVICE PLAN WITH ACTION STEPS IN THE PAST 12 MONTHS; OTHERWISE, CHECK NO. THEN FILL IN THE CODES FOR THE TYPE AND FREQUENCY OF SUPPORT TYPICALLY NEEDED DURING WAKING HOURS FOR EACH UNUSUAL BEHAVIOR. TREATMENT PLANS WITH ACTION STEPS INCLUDE STRATEGIES TO: 1) CHANGE A BEHAVIOR; 2) REPLACE A BEHAVIOR; 3) ADDRESS A BEHAVIOR THROUGH SUPPORT STRATEGIES. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Unusual Behavioral Supports	No ✓	Yes ✓	Support	✓	Frequency	✓	Unmet Need ✓
34. Sexually inappropriate behavior in past 12 months (Includes a wide range of behaviors such as disrobing, sexually inappropriate comments, masturbating in public, as well as sexually aggressive behavior).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
35. Criminal concerns in past 12 months (Includes any criminal justice issues or concerns, or problems with the law).	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
36. Serious suicide attempt or serious threat made in the past 12 months. *please refer to manual for explanation*	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		
37. Attempted to/or set fires in the past 12 months.	☐	☐	No support needed		Episodic		☐
			Monitor		Less Monthly		
			Verbal Redirection		Monthly		
			Hands-on Support		Weekly		
					Daily		

Is attention required during overnight? No ☐ Yes ☐
What page and paragraph can a detailed description of unmet need be found in the service plan?

Support Required	Support Frequency
• No Support Needed=No support needed or can ignore behavior. • Monitor=Monitor only, using a person or through environmental means. Includes monitoring for behaviors addressed by medications or treatment plan. • Verbal Redirection=Verbal or gestural Redirection or prompting typically needed. • Hands-on Support=One person hands-on support typically needed to redirect or Support person.	• Controlled=Condition is well controlled or stable (includes controlled by medication or other means) • Intermittent=Condition is intermittent or episodic • Uncontrolled=Condition is uncontrolled or currently in crisis

PLEASE CHECK YES FOR ANY DIAGNOSED MENTAL HEALTH CONDITIONS SUPPORTED OR JUSTIFIED IN THE SERVICE PLAN WITH ACTION STEPS IN THE PAST 12 MONTHS; OTHERWISE, CHECK NO. THEN FILL IN THE CODES FOR THE TYPE AND FREQUENCY OF SUPPORT TYPICALLY NEEDED DURING WAKING HOURS FOR EACH PSYCHIATRIC CONDITION. DIAGNOSIS MUST BE BASED ON ORIGINAL SOURCE DOCUMENTATION FROM A LICENSED CLINICIAN. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Psychiatric or Mental Health Axis I Diagnosis	No ✓	Yes ✓	Support	✓	Frequency	✓	Unmet Need ✓
38. Diagnosed psychotic disorder (Includes schizophrenia, psychosis, schizoaffective disorder, etc. Write in formal diagnosis). _____ _____	☐	☐	No support needed Monitor Verbal Redirection Hands-on Support		Controlled Intermittent Uncontrolled		☐
39. Diagnosed mood disorder (Includes bipolar disorder, major depression, depressive disorder, etc. Write in formal diagnosis). _____ _____	☐	☐	No support needed Monitor Verbal Redirection Hands-on Support		Controlled Intermittent Uncontrolled		☐

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

Support Frequency

- No Support Needed=No support needed for prescribed medical treatments
- Less than Weekly=Less than one time per week
- Once a Week=Once a week
- Several Times a Week=Two or more times per week
- Once a Day=Once a day
- Multiple Times a Day=Multiple times a day

PLEASE CHECK YES FOR ANY PRESCRIBED MEDICAL TREATMENTS, PROCEDURES OR CONDITIONS SUPPORTED OR JUSTIFIED IN THE SERVICE PLAN; OTHERWISE, CHECK NO. SUPPORT FREQUENCY REFERS TO THE AMOUNT OF CARE ASSOCIATED WITH THE TREATMENT, RATHER THAN THE FACT THAT THE PERSON ALWAYS USES ONE. DO NOT INCLUDE TIME REQUIRED FOR MEDICAL OFFICE VISITS OR OFF-SITE MEDICAL TREATMENTS. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Prescribed Medical Treatments	No ✓	Yes ✓	Frequency	✓
40. Artificial ventilator – This refers to mechanical ventilators which breathe for the person and are on continuously. Consider care and monitoring of ventilator.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
41. Catheter – If catheter is used continuously, consider catheter care only, such as insertion, removal, cleaning and emptying bag.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
42. Inhalation therapy or nebulizer – Consider how often each treatment is needed. This does not include oxygen.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
43. Needle injection – Consider how often an injection is given.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
44. Ostomy (colostomy or ileostomy) – Consider care related to the ostomy, such as cleaning the tube area of emptying the bag.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
45. Oxygen – If the oxygen is used continuously, consider how often care is needed to administer the oxygen; otherwise consider how often oxygen is needed.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			

Prescribed Medical Treatments	No ✓	Yes ✓	Frequency	✓
46. Postural Drainage/Chest PT – Consider how often postural drainage or chest PT is needed.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
47. Respiratory suctioning – Consider how often respiratory suctioning is needed.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
48. Seizure disorder care (includes grand mal or convulsive seizure).	☐	☐	No Support/Controlled Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
49. Tracheostomy – Consider care of stoma, cannula, and any other trach care.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			
50. Tube/IV Feeding (nasogastric, G or J tube, IV) – Consider how often tube/IV feeding is required.	☐	☐	No Support Less than weekly Once a week Several times a week Once a day Multiple times day	
	Unmet Need? ☐			

Is attention required during overnight? No ☐ Yes ☐
What page and paragraph can a detailed description of unmet need be found in the service plan?

PLEASE CHECK YES FOR ANY DIAGNOSED CONDITION THAT REQUIRES MONITORING BY A LICENSED PROFESSIONAL AND AN ACTIVE TREATMENT PLAN IN THE PAST 12 MONTHS; OTHERWISE, CHECK NO. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM.

Diagnosed Health Conditions	No ✓	Yes ✓	Unmet Need ✓	Diagnosed Health Conditions	No ✓	Yes ✓	Unmet Need ✓
51. Arthritis	☐	☐	☐	62. Injuries and/or falls that require medical attention at least monthly	☐	☐	☐
52. Cancer	☐	☐	☐	63. Lung disease (COPD, emphysema, pulmonary edema, asthma)	☐	☐	☐
53. Choking that requires attention at least daily	☐	☐	☐	64. Ongoing open wound care	☐	☐	☐
54. Chronic pain	☐	☐	☐	65. Orthopedic conditions (e.g., scoliosis, hip dysplasia, contractures)	☐	☐	☐
55. Dementia/Alzheimer's disease	☐	☐	☐	66. Ongoing skin breakdowns	☐	☐	☐
56. Diabetes (controlled by diet , oral medications, or injections)	☐	☐	☐	67. Pregnancy	☐	☐	☐
57. Diabetes (controlled by injections given at a medical facility)	☐	☐	☐	68. Stroke	☐	☐	☐
58. Dialysis	☐	☐	☐	69. Other neurological impairment (included meningitis, hydrocephalus, etc.)	☐	☐	☐
59. Frequent medical visits (monthly)	☐	☐	☐	70. Other _____	☐	☐	☐
60. . Frequent medical visits (weekly or more)	☐	☐	☐	71. Other _____	☐	☐	☐
61 History of suicide attempts or serious threats—active treatment plan in place	☐	☐	☐				

Is attention required during overnight? No ☐ Yes ☐

What page and paragraph can a detailed description of unmet need be found in the service plan?

PLEASE CHECK YES FOR ANY DEVELOPMENTAL DISABILITY DIAGNOSIS.

Developmental Disability Diagnosis	No ✓	Yes ✓	Developmental Disability Diagnosis	No ✓	Yes ✓
72. Mental retardation	☐	☐	77. Autism, Asperger's Syndrome, or pervasive developmental disorder	☐	☐
73. Cerebral palsy	☐	☐	78. Brain injury (TBI, ABI)	☐	☐
74. Down syndrome	☐	☐	79. Spina bifida	☐	☐
75. Prader Willi	☐	☐	80. Other_____	☐	☐
76. Other chromosomal disorder (Fragile X, Klinefelter's Syndrome, etc.)	☐	☐	81. Other_____	☐	☐

PLEASE CHECK YES FOR THE SOCIAL SUPPORTS CATEGORY THAT IS MOST REFLECTIVE OF THE PERSON'S SITUATION AND NEED FOR FUTURE PLANNING ACTIVITIES

Natural Supports	No ✓	Yes ✓	Does not impact care	Slight impact on care—no actions required	Moderate impact on care—begin planning in the next 3 years	Heavy impact on care—begin planning in the next 12 months	Emergency—immediate intervention is needed
Person has no natural supports SKIP THIS SECTION							
82. Death of primary caregiver	☐	☐	☐	☐	☐	☐	☐
83. Primary caregiver has diagnosed terminal diagnosis	☐	☐	☐	☐	☐	☐	☐
84. Single caregiver family	☐	☐	☐	☐	☐	☐	☐
85. Risk of removal from home as evidenced by an open Children's Division investigation	☐	☐	☐	☐	☐	☐	☐
86. Primary caregiver has a documented intellectual disability	☐	☐	☐	☐	☐	☐	☐
87. Primary caregiver has a documented mental diagnosis (includes memory problems)	☐	☐	☐	☐	☐	☐	☐
88. Primary caregiver has no access to backup caregivers	☐	☐	☐	☐	☐	☐	☐
89. Primary caregiver caring for an aging parent, ill spouse, or other relative with disabilities	☐	☐	☐	☐	☐	☐	☐
90. Primary caregiver works	☐	☐	☐	☐	☐	☐	☐
91. Primary caregiver has a physical disability/chronic disease/incapacitated	☐	☐	☐	☐	☐	☐	☐
92. Primary caregiver has more than 3 children under the age of 10 living in the home	☐	☐	☐	☐	☐	☐	☐
93. Family has no permanent home	☐	☐	☐	☐	☐	☐	☐
94 Family /person is at risk of losing home due to financial constraints	☐	☐	☐	☐	☐	☐	☐
95. Primary caregiver is facing jail time	☐	☐	☐	☐	☐	☐	☐
96. Environment with domestic/sexual violence as evidenced by police reports	☐	☐	☐	☐	☐	☐	☐
97. Temporary care giving arrangement *please see manual*	☐	☐	☐	☐	☐	☐	☐
98. Primary caregiver lost employment	☐	☐	☐	☐	☐	☐	☐
99. Other_____	☐	☐	☐	☐	☐	☐	☐

What page and paragraph can a detailed description of the impact be found in the service plan?

This document was produced under grant CFDA 93.779 from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.