

Needs Assessment Questionnaire (NAQ) Tool

Sections:

- A. Diagnoses**
- B. Personal Care Supports**
- C. Daily Living Supports**
- D. Safety Supports**
- E. Behavior Supports**
- F. Prescribed Medical Treatments**
- G. Caregiver & Home Environment**
- H. Desired/Needed Services**
- U. Urgent Need**

Note: Please consult the accompanying manual for more guidance on understanding the intent of questions.

| Identifiers for Pilot Test | | | | | |
|----------------------------|----------------------|----------------------------|-------------------------------------|---------------------------------|-------------------|
| Client Initials | Client Date of Birth | Current Waiting List Score | Date of Most Recent Wait List Score | Date of Initial Wait List Score | Assessor Initials |
| | | | | | |

| Waiver Category | |
|--------------------------|-------------------------|
| <input type="checkbox"/> | Intellectual Disability |
| <input type="checkbox"/> | Physical Disability |
| <input type="checkbox"/> | Brain Injury |

| Health Care Facility Residence | |
|---|--|
| Is the applicant currently living in a licensed health care facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Section U: Urgent Need | No ✓ | Yes ✓ |
|---|--------------------------|--------------------------|
| U1. After following up with APS/DCFS in the case of a positive electronic match, is the applicant a good candidate for ESMC referral? | <input type="checkbox"/> | <input type="checkbox"/> |
| U2. Has the applicant been court ordered to receive services? | <input type="checkbox"/> | <input type="checkbox"/> |
| U3. Has the applicant been approved for funding under a cooperative agreement? | <input type="checkbox"/> | <input type="checkbox"/> |
| U4. Is the applicant either currently, or at imminent risk of in the next 30 days, living on the street or in a homeless shelter or domestic violence shelter? | <input type="checkbox"/> | <input type="checkbox"/> |
| U5. Is the applicant at imminent risk of profoundly endangering self or others in the next 30 days? (i.e. death, dismemberment, permanent injury due to an unmet need associated with their disability) | <input type="checkbox"/> | <input type="checkbox"/> |
| U6. Is the applicant without a caregiver to meet his/her life-sustaining needs? | <input type="checkbox"/> | <input type="checkbox"/> |
| U7. Is the applicant at imminent risk of not having a primary caregiver in the next 30 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section U Notes: Explain "yes" responses below: | | |

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| Section A: Diagnoses | | | | | | | |
|--|--------------------------|---|---|--------------------------|--|--------------------------|--------------------------|
| <i>Please check yes for any diagnosed condition that requires monitoring by a licensed professional in the <u>past 12 months</u>; otherwise, check no.</i> | | | | | | | |
| Intellectual/Developmental Disability Diagnoses | | | Psychiatric or Mental Health Diagnoses | | | | |
| No ✓ | Yes ✓ | | No ✓ | Yes ✓ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A1. Intellectual Disability | <input type="checkbox"/> | <input type="checkbox"/> | A5. Autism Spectrum Disorder | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A2. Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | A6. Spina Bifida | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A3. Down Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | A7. Seizure Disorders | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A4. Prader Willi | <input type="checkbox"/> | <input type="checkbox"/> | A8. Other intellectual or developmental disability _____ | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | A9. Diagnosed psychotic disorder (Includes schizophrenia, psychosis, schizoaffective disorder, dementia, paranoia, etc. Write in the formal diagnosis). _____ | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | A10. Diagnosed mood disorder (Includes bipolar disorder, major depression, depressive disorder, anxiety disorders, etc. Write in formal diagnosis). _____ | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | A11. List Other Mental Health Diagnosis from licensed clinician (includes PTSD): _____ | | |
| Diagnosed Health Conditions Requiring Monitoring | | | No ✓ | Yes ✓ | No ✓ | Yes ✓ | |
| <input type="checkbox"/> | <input type="checkbox"/> | A12. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | A23. Quadriplegia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A13. Dementia/Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> | A24. Paraplegia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A14. Chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | A25. Hemiplegia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A15. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | A26. Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A16. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | A27. Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A17. Fetal alcohol syndrome | <input type="checkbox"/> | <input type="checkbox"/> | A28. Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A18. Lung Disease (COPD, emphysema, pulmonary edema, asthma) | <input type="checkbox"/> | <input type="checkbox"/> | A29. Spinal Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A19. Orthopedic Conditions (e.g., scoliosis, hip dysplasia, contractures) | <input type="checkbox"/> | <input type="checkbox"/> | A30. Amyotrophic Lateral Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A20. Substance abuse | <input type="checkbox"/> | <input type="checkbox"/> | A31. Acquired Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A21. Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | A32. Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A22. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | A33. Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Section A Notes: | | | | | | | |

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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.

| Section B: Personal Care Supports | Supports Required | Unmet need (Requires explanation below) |
|--|---------------------------|--|
| B1. Chewing and Swallowing – Includes ability to chew food and swallow food without choking. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B2. 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 | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B3. Dressing and Undressing – Includes ability to take clothes out of drawers, choose weather appropriate clothes, and use of fasteners. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B4. Grooming and Personal Care – Includes brushing teeth or hair, shaving, or applying deodorant. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B5. Using the Toilet – Includes going to the bathroom for bowel and urine elimination, wiping self, menstruation care, diaper care, and ostomy/catheter care. Also includes ability to clean up from accidents. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B6. Bathing or Showering – Includes sponge bath, tub bath or shower. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B7. Sleeping/Waking – Includes ability to wake up. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B8. Changing Position in Bed – Includes ability to turn side to side. Does not include ability to get out of bed or chair. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B9. Transferring – Includes ability to move from bed to a chair or to a wheelchair. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| B10. Mobility in the Home – Includes the ability to move around inside the home or residence. See manual for instructions for individuals who are wheelchair dependent or utilize a cane or walker. | Independent | <input type="checkbox"/> |
| | Monitoring | |
| | Partial assistance | |
| | Total hands-on assistance | |
| Section B Notes: | | |
| <p>Explain reason the need is unmet.</p> | | |

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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.

| Section C: Daily Living Supports | Support Required | | Unmet need (Requires explanation below) |
|---|---------------------------|--------------------------|--|
| | Independent | Monitoring | |
| C1. Mobility in the Community – Includes the ability to move around outside and utilize transportation to access the community. This question is not merely to assess ambulation (as in B10). | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C2. Taking Medications – Includes taking the correct medication, accurate dose, and proper consistency (e.g., crushed) at the correct time. <i>A list of prescription medications can be detailed in the appendix.</i> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C3. Doing Household Chores – Includes housecleaning, laundry, etc. | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C4. Shopping – Includes shopping for groceries or other goods in neighborhood area. | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C5. Meal Planning, Preparation and Cooking – Includes planning for meals, getting the food out of the cupboard or refrigerator, preparing food; includes management of special dietary needs. | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C6. Using the Telephone – Includes use of communication devices broadly defined. | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| C7. Financial management – Includes ability to manage bank accounts and pay bills. | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | Monitoring | <input type="checkbox"/> | |
| | Partial assistance | <input type="checkbox"/> | |
| | Total hands-on assistance | <input type="checkbox"/> | |
| Section C Notes: | | | |
| <p>Explain reason the need is unmet.</p> | | | |

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

| Section D: Safety Supports | Def. No | Prob. No | Prob. Yes | Def. Yes | Unmet need (Requires explanation below) |
|--|--------------------------|--------------------------|--------------------------|--------------------------|---|
| D1. The person requires 2 people for transferring or fire evacuation. | <input type="checkbox"/> |
| D2. 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. | <input type="checkbox"/> |
| D3. Overall, the person usually makes safe choices when <u>at home</u> – for example, not putting metal in a microwave or toaster, not opening the door to strangers. | <input type="checkbox"/> |
| D4. Overall, the person usually makes safe choices when <u>not at home</u> – for example, refusing a ride from a stranger or staying out of traffic. | <input type="checkbox"/> |
| D5. The person is able to avoid being taken advantage of financially – for example, not giving out personal financial or social security information to strangers or not giving his/her money to strangers. | <input type="checkbox"/> |
| D6. 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. | <input type="checkbox"/> |

Section D Notes:

Explain reason the need is unmet.

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| PLEASE CHECK YES FOR ANY BEHAVIORS EXHIBITED <u>IN THE PAST 12 MONTHS</u> . OTHERWISE, CHECK NO. THEN FILL IN THE CODES FOR THE FREQUENCY AND TYPE OF SUPPORT TYPICALLY NEEDED DURING WAKING HOURS FOR EACH BEHAVIOR. FOR EACH ITEM, INDICATE IF THERE IS AN UNMET NEED PLACING A PERSON AT RISK OF ILLNESS, INJURY OR HARM. | | | | |
|--|--------------------------|--------------------------|----------------------|--|
| Section E: Behavioral Supports | No | Yes | Frequency | Unmet need (Requires explanation below) |
| | ✓ | ✓ | | |
| E1. Wandering away – Includes wandering away only; bolting is covered in the next question. See manual for notes on the distinction between wandering and bolting. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E2. Bolting – Includes suddenly running or quickly darting away; excludes wandering away, which is covered above. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E3. Disordered eating – Includes Impulsive food or liquid ingestion such as binge eating or compulsive/rapid ingestion of large quantities of food or liquid. Also includes eating disorders such as anorexia or bulimia. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E4. Eating or drinking <u>nonfood</u> items (pica) – Includes ingestion of items or liquids not meant for food such as paper clips, coins, detergent, dirt, cleaning solutions, etc. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E5. Self-injurious behavior – Includes any behavior which harms one’s physical self, such as head banging, biting/hitting self, skin picking, scratching self, etc. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E6. Refuses support or assistance – Includes behavior that places the individual at risk of illness, injury or harm such as resisting care or assistance. Also includes repetitive autistic behaviors (e.g. obsessive rigidity in schedules). | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E7. Property destruction – Includes the intentional destruction of property as well as compulsive behavior that leads to property destruction. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E8. Disruptive behaviors, <u>not physical or verbal aggression</u> – Includes any behavior which disrupts or interferes with activities of the person or others, such as socially disruptive or offensive behavior like urinating in public, defecating and smearing, or yelling in inappropriate venues. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E9. Verbal aggression or emotional outbursts – Includes verbal threats, name calling, verbal outbursts, temper tantrums, extreme agitation, and combative behavior. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E10. Mild physical assaults or aggression – Includes mild behaviors that do not cause injury such as pushing, grabbing, or spitting. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |
| E11. Severe physical assault or aggression – Includes more severe behavior that causes injury such as biting, punching, or attacking. | <input type="checkbox"/> | <input type="checkbox"/> | Episodic | <input type="checkbox"/> |
| | | | Weekly | |
| | | | Daily | |
| | | | More than once a day | |

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PLEASE CHECK YES FOR ANY PRESCRIBED MEDICAL TREATMENTS, PROCEDURES OR; OTHERWISE, CHECK NO. SUPPORT FREQUENCY REFERS TO THE AMOUNT OF CARE ASSOCIATED WITH THE TREATMENT PROVIDED BY A CAREGIVER. 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.

| Section F: Prescribed Medical Treatments | | No ✓ | Yes ✓ | Support | ✓ | Unmet need? |
|---|--|--------------------------|--------------------------|---------------------------------|---|--------------------------|
| F1. Catheter – If catheter is used continuously, consider catheter care only, such as insertion, removal, cleaning and emptying bag. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F2. Ostomy (colostomy or ileostomy) – Consider care related to the ostomy, such as cleaning the tube area of emptying the bag. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F3. Artificial ventilator – This refers to mechanical ventilators, which breathe for the person and are used continuously. Consider care and monitoring of ventilator. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F4. Inhalation therapy or nebulizer –This does not include oxygen. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F5. Tracheostomy – Consider care of stoma, cannula, and any other trach care | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F6. Oxygen – If the oxygen is used continuously, consider how often care is needed to administer the oxygen; otherwise consider how often oxygen is needed. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F7. Allergy treatments – Includes use of injection or oral medication for anaphylaxis or other serious allergic reactions. | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |
| F8. Postural Drainage/Chest PT | | <input type="checkbox"/> | <input type="checkbox"/> | Independent | | <input type="checkbox"/> |
| | | | | Minimal support | | |
| | | | | Hands-on episodic | | |
| | | | | Hands-on weekly | | |
| | | | | Hands-on daily | | |
| | | | | Hands-on multiple times per day | | |

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| Section F: Prescribed Medical Treatments (cont.) | No ✓ | Yes ✓ | Support | ✓ | Unmet need? |
|---|-----------------------------|---|---------------------------------|--------------------------|--------------------------|
| F9. Respiratory suctioning | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F10. Seizure disorder care (includes grand mal or convulsive seizure). | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F11. Needle injection (including insulin or other subcutaneous injections) | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F12. IV Infusion or Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F13. Ongoing wound care | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F14. Other prescribed medical treatments, specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Independent | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Minimal support | <input type="checkbox"/> | |
| | | | Hands-on episodic | <input type="checkbox"/> | |
| | | | Hands-on weekly | <input type="checkbox"/> | |
| | | | Hands-on daily | <input type="checkbox"/> | |
| | | | Hands-on multiple times per day | <input type="checkbox"/> | |
| F15. Frequent medical visits that require caregiver support to attend. | <input type="checkbox"/> No | <input type="checkbox"/> Yes, indicate frequency: <input type="checkbox"/> minimal <input type="checkbox"/> episodic <input type="checkbox"/> weekly <input type="checkbox"/> daily <input type="checkbox"/> multiple times/day | | | |
| Section F Notes: Explain reason need is unmet. | | | | | |

Note: Prescription medications may be noted in the appendix.

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| Section G: Caregiver & Home Environment | | No ✓ | Yes ✓ | Impact on care | ✓ |
|--|----------------------------|--------------------------|-------------------------|--------------------------|---|
| G1. No caregiver | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G2. Primary caregiver has terminal diagnosis | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G3. Single caregiver family | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G4. Primary caregiver works | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G5. Primary caregiver has no access to backup caregivers | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G6. Primary caregiver has a mental health condition | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G7. Primary caregiver has an intellectual disability | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G8. Primary caregiver has a physical disability or chronic disease that impacts the ability to provide care | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G9. Primary caregiver is caring for an aging parent, ill spouse, or dependent with disabilities in addition to the applicant | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G10. Primary caregiver has other young children living in the home | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G11. Environment with domestic violence | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G12. Primary caregiver is facing jail time | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |
| G13. Recent significant drop in family income (*see manual) | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> | |
| | | | Moderate impact on care | <input type="checkbox"/> | |
| | | | Heavy impact on care | <input type="checkbox"/> | |
| | | | Emergency | <input type="checkbox"/> | |

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| Section G: Caregiver & Home Environment (cont.) | | No ✓ | Yes ✓ | Impact on care | ✓ |
|---|---|----------------------------|--------------------------|-------------------------|--|
| G14. Family /person lacks a permanent home or is at risk of losing home | | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> |
| | | | | Moderate impact on care | <input type="checkbox"/> |
| | | | | Heavy impact on care | <input type="checkbox"/> |
| | | | | Emergency | <input type="checkbox"/> |
| G15. Temporary caregiving arrangement (*see manual) | | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> |
| | | | | Moderate impact on care | <input type="checkbox"/> |
| | | | | Heavy impact on care | <input type="checkbox"/> |
| | | | | Emergency | <input type="checkbox"/> |
| G16. Other (please describe in notes): | | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> |
| | | | | Moderate impact on care | <input type="checkbox"/> |
| | | | | Heavy impact on care | <input type="checkbox"/> |
| | | | | Emergency | <input type="checkbox"/> |
| G17. School services are expected to end in the next 12 months. | | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> |
| | | | | Moderate impact on care | <input type="checkbox"/> |
| | | | | Heavy impact on care | <input type="checkbox"/> |
| | | | | Emergency | <input type="checkbox"/> |
| G18. Other services (e.g. private pay services) are expected to end in the next 12 months? | | <input type="checkbox"/> 0 | <input type="checkbox"/> | Does not impact care | <input type="checkbox"/> |
| | | | | Moderate impact on care | <input type="checkbox"/> |
| | | | | Heavy impact on care | <input type="checkbox"/> |
| | | | | Emergency | <input type="checkbox"/> |
| G19. Hours of Daily Support Needed: (unscored) | A. Hours a day the applicant sleeps B. Hours a day the applicant spends at school, day programs or work. C. Hours a day the applicant can be on their own with minimal supervision. D. Hours a day the applicant requires more than minimal supervision – outside of school, day programs, or work. Total must equal 24 hours | | | | A. _____ B. _____ C. _____ D. _____ _____ 24 |
| G20. Thinking about all of the needs addressed in this document, does the applicant require direct hands-on assistance overnight? | <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, note the frequency | | | Occasionally | <input type="checkbox"/> |
| | | | | Several times a week | <input type="checkbox"/> |
| | | | | Nightly | <input type="checkbox"/> |
| | | | | Multiple times a night | <input type="checkbox"/> |
| Section G Notes: | | | | | |
| For any questions marked “yes” above, please briefly explain the details of the situation and how it impacts care. | | | | | |

Appendix (optional):

| Descriptive Narrative |
|--|
| <p>Provide a description of a typical day for the applicant and their family/caregivers including areas of strength as well as challenges. The purpose of this section is to provide holistic picture of the applicant for DSPD staff.</p> |

| Desired/Needed Services Expressed by Applicant | |
|--|--|
| DSPD services | |
| Wait list services | |
| Other services (not related to DSPD) | |
| Medicaid | |

| Services Currently Received |
|-----------------------------|
| |

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| Prescription Medication | <i>Dosage</i> |
|-------------------------|---------------|
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