PHYSICAL DISABILITIES CRITICAL NEEDS ASSESSMENT

(check one) Initial Assessment [ ] Petitioned Assessment [ ]

Person’s Name: _______________________________ Date: __________________
ID Number: _________________________________ Worker: __________________

Does this person have the cognitive ability to self-direct a personal assistant? __ yes    __ no

Desired / Needed Services:
Attendant
Personal Response System
Consumer Preparation
Liaison Services

Supports Currently Received:
Home Health/CNA: ___________________________
Medication Management: ______________________
Residential: _________________________________
Other: ________________________________

1. Support System: (Score range 0 to 7)

Describe the composition of natural supports provided by family and friends. Does the person live with parents? Are the person’s parents elderly? Do other individuals with special needs live at home? How is the health of the primary care giver? Does the person receive SSI, Medicaid, Housing Assistance? Does the person enjoy financial stability, hold a job, etc?

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

2. Special Medical Needs: (0 to 10 points)

Assess the person’s physical health, are there problems? What special adaptive equipment is necessary for the person?

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

3. Protective Service Issues: (0 to 9 points)

List issues facing the person (homelessness, abuse, neglect, exploitation, financial exploitation, etc.).

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

4. Projected Deterioration Issues: (0 to 9 points)

What will happen if the waiver service is not provided immediately? (divorce, deterioration of family, death of care giver, etc.).

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

5. Resources/Supports Needed: (0 to 10 points)

Considering all supports/resources currently available to the person (e.g., other agencies, church, friends, community, family, school, etc.) what further supports does the person need?

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Diagnosed Conditions:
(check all that apply)
__ Physical Disability
__ Cause
__ Paraplegia
__ Date of Onset
__ Cerebral Palsy
__ MS
__ Neurological
__ Mental Illness
__ Deafness
__ Blind
__ Other
### PERSONAL ASSISTANCE CRITICAL NEEDS ASSESSMENT

_____ 6. Functional Status:  (0 to 54 points)

Rate each functional activity listed below using the rating scale on the right, then determine the approximate hours of personal support per week the person will need using the total score and the Personal Assistance Hours Needed chart.

<table>
<thead>
<tr>
<th>FUNCTIONAL STATUS/ACTIVITY</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In/out of bed</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>2. In/out of chair</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>3. Toileting</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>4. Bathe</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>5. Groom</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>6. Dress/undress</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>7. Drink/eat</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>8. Take medication</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>9. Mobility in home</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>10. Use telephone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>11. Prepare meals</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>12. Dishes</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>13. Clean House</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>14. Laundry</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>15. Admit visitors</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>16. Manage finances/mail</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>17. Socialize</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>18. Communicate</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

**TOTAL SCORE_____**

_____ 7. Time on Waiting List:  (0 to 10 points)

Total the length of time the person has been on the waiting list from the date the application was received (1 point for every ½ year, up to 10 points maximum).

**TOTAL SCORE (100 points possible)**

Nurse Coordinator ___________________________ Date __________

Nurse Coordinator ___________________________ Date __________