Division of Services for People with Disabilities
BRAIN INJURY WAIVER
Version 2.0
Intake, Screening, and Assessment Form
(Purpose: Part of assessment on determining ABI eligibility for State Funds)

SECTION I

A. Applicant Information **Date:** _____

Name: _____ Social Security Number: _____- ____- _____
Client ID #: _____ Phone Number: ( ) _____ - _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____
Date of Birth (MM/DD/YYYY): _____ / _____ / _____ Gender: M _____ F _____
Height: _____ Weight: _____
US Citizen or legal resident: Yes _____ No _____ Country of origin: _____

Ethnic Background	**Primary Language**	**Prim. Means of Expression**
❑ Caucasian	❑ English	❑ None
❑ Asian or Pacific Islander	❑ Spanish	❑ Sign Language
❑ African-American	❑ Other	❑ Gestures
❑ American Indian	Can client speak English?	❑ Communication Board
❑ Alaskan Native	❑ Yes ❑ No	❑ Speaks
❑ Hispanic	Understand English?	❑ Other:
❑ Other (Specify):	❑ Yes ❑ No	

What problems are you having right now that causes you difficulty? How long have you had these problems? What services are you receiving? (If no answer is given, state reason: e.g., unable to answer question.)

_____
_____
_____
_____

Marital Status

❑ Married Spouse Name: _____
❑ Divorced Age: _____
❑ Widowed Social Security Number: _____ - _____- _____
❑ Single
❑ Unknown

Legal Status

❑ Legally competent adult
❑ Parent or relative is guardian or conservator. Name: _____
❑ Non-relative is guardian or conservator Address: _____
❑ State or country is guardian or conservator City: _____ State: _____
❑ Other: _____ Zip: _____ Ph: ( ) _____

Client's Residence

❑ Private Residence ❑ Residential Care ❑ Other

Provider ID#: _____

Is client homebound? ❑ Yes ❑ No

Health Insurance: Check Appropriate Boxes

❑ Medicare Part A Medicare # _____

❑ Medicare Part B Medicaid # _____

❑ Medicaid Medicaid application pending? ❑ Yes ❑ No

❑ Veteran's Administration Date of application: _____

❑ HMO

❑ Other health insurance (Specify)

❑ Don't know

Diagnostic Status

Primary Diagnosis:

❑ Brain Injury (Qualifying Dx?)

❑ Brain Injury/ deteriorating disease (Exclusionary Dx)

❑ Mental Retardation (MR) (Exclusionary Dx)

❑ Related Condition

Additional Diagnosis Conditions (check all that apply)

❑ None

❑ Autism

❑ Blindness/ Visual Impairment

❑ Substance Abuse

❑ Depression/ Anxiety

❑ Mental Health not depr. or anx. (i.e. Schizophrenia)

❑ Deafness/ Hearing Impairment

❑ Personality Disorder

❑ Epilepsy or Seizures

❑ Learning Disabilities

❑ Physical health problems req. medical care

❑ Cerebral Palsy

❑ Behavior Disorder

❑ Aging Process

❑ Mental Retardation

❑ Other:_____

Environmental Assessments

Life and Safety Issues

Are you concerned about the safety of your neighborhood? ❑ Yes ❑ No

Please list any problems:

_____

_____

_____

_____

Brain Injury Waiver Comprehensive Assessment Form

SECTION II

Mental Status Questionnaire (MSQ) Orientation-Memory-Concentration Test (Katzman 35.al., 1983)

Write in answers to the questions in the applicant response box. Do **not** try to score until after evaluation. Score 1 for each incorrect response up to maximum errors for the item. In scoring, a "no" response is treated as incorrect.

Items	Maximum Errors	Applicant Response	Score	Weight	Weighted Score Maximum score 4 / 3
1. What year is it now?	1			X 4	
2. What Month is it now?	1			X 3	

Tell the client that you are giving him or her a man's name and address to memorize. Note: This information will be used in question #6 below.
Phrase to memorize: **John Brown, 42 Market Street, Chicago**
Repeat 3 times before moving on to next question.

Items	Maximum Errors	Applicant Response	Score	Weight	Weighted Score Maximum score 3
3. Without looking at a clock, about what time is it?	1			X 3	

Items	Maximum Errors	Score	Weight	Weighted Score Maximum score 2
4. Count backward from 20 to 1. (Mark missed/out of order boxes with a slash [/] mark)	1		X 2	

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

Items	Maximum Errors	Score	Weight	Weighted Score Maximum score 6
5.Say the months in reverse order. (Mark missed/out of order boxes with a slash [/] mark)	2		X 3	

	Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	April	Marc	Feb.	Jan.

Items	Maximum Errors	Score	Weight	Weighted Score Maximum score 10
6. Ask the client to repeat the memory phrase. (Write the client's response on the line below. Each word missed counts as 1 point.)	5		X 2	

	John (1)	Brown (1)	42 (1)	Market Street (1)	Chicago (1)	

SECTION II 1-6; Maximum Weighted Score is **28**	Individual's Total Weighted Score (for items 1-6)

Cognitive Deficits

Use the scale below to assess the applicant's cognitive deficits (questions 7-11). Please write in the scores for cognitive deficits. Descriptions of the cognitive deficits must be included.
Note: Please refer to the manual to identify the descriptions for each function listed below.

0	No Problem	Applicant has intact abilities
1	Minimal Problem	Problems do not interfere with independence and activities of daily living, but may compromise functioning in complex activities.
2	Mild Problem	Problems do not interfere with independence in routine and familiar situations, but may limit independence or impair functions in complex or unfamiliar activities. Requires cueing to either start or complete a task.
3	Mild-Moderate Problem	Problems limit independence and interfere with functioning in routine and familiar situations. May require supervision for some activities, but able to stay alone for periods of time. Requires cueing and/or occasional assistance to start and complete a task.
4	Moderate Problem	Problems limit independence and interfere with functioning in routine and familiar situations, needing moderate levels of assistance and supervision. Required occasional supervision and/or assistance to complete a task.
5	Moderate-Severe Problem	Problems limit independence and interfere with functioning in routine and familiar situations, needing maximum assistance and constant supervision. Requires maximum supervision and/or assistance to complete a task.
6	Severe Problem	Applicant requires constant visual supervision during day and nighttime awake staff. Completely dependent.

7. Attention and Concentration Score: _____

Describe:_____
_____
_____

8. Learning and Memory Score: _____

Describe:_____
_____
_____

9. Judgment and Perception	Score: _____

Describe:_____
_____
_____

10. Initiation and Planning	Score: _____

Describe:_____
_____
_____

11. Communication	Score: _____

Describe:_____
_____
_____

SECTION II 7-11; Maximum Score is **30**.	Individual's Total Cognitive Deficits Score (for items 7-11)

Brain Injury Waiver Comprehensive Assessment Form
Health Assessment

SECTION III

A. Health Problems

1. Do you have any health problems other than a brain injury that affects your daily living? *There is **no score** for these responses. Information use only.*

Health Conditions	
	Assessment
Allergies (type: drug/skin/etc:)	
Anemia (type:)	
Arthritis (type:)	
Asthma (type:)	
Bladder/kidney problems, UTI, etc:	
Falls that occurred during the past year:	
Hearing Problems	
Paralysis (site:)	
Seizure disorders (epilepsy, etc.)	
Sleep problems:	
Stroke (CVA):	
Thyroid problems (graves, myxedema, etc.)	
Ulcers (type, site:)	
Vision problems (cataracts, glaucoma, etc.)	
Other (specify:)	

2. How do you remember to take your medications? (Do not read list. Check answer.) *There is **no score** for these responses. Information use only.*

Medication Use	
	Assessment
Care giver gives them	
Egg carton, envelopes	
Plastic pill minder	
Calendar	
Follows directions on label	
Other (specify:)	

3. **The Interviewer may answer it himself or ask support team. You may also ask the consumer directly.** Are you concerned that the client is: (**Each affirmative answer is worth 2 points. There is no maximum.)**

Scored Medication Use			
	Score		Comments:
Not taking medications on time?	❑ Y (2)	❑ N (0)	
Not taking the proper number of medications?	❑ Y (2)	❑ N (0)	
Taking medications prescribed for other?	❑ Y (2)	❑ N (0)	
Not getting prescriptions properly filled?	❑ Y (2)	❑ N (0)	
Not getting medication needs reevaluated?	❑ Y (2)	❑ N (0)	
Not getting medications due to cost?	❑ Y (2)	❑ N (0)	
Affected by medication side effects?	❑ Y (2)	❑ N (0)	
Taking prescriptions from too many physicians?	❑ Y (2)	❑ N (0)	
Using outdated medications?	❑ Y (2)	❑ N (0)	
Refusing to take medications?	❑ Y (2)	❑ N (0)	
Other Medication Problems?	❑ Y (2)	❑ N (0)	

4. Do you take 3 or more prescribed or over the counter medications daily? (Score 2 if answer is yes.)

Three or More Medications		
❑ Y (2)	❑ N (0)	

Medications	
Prescription (if yes, please list)	

Medications	
Over the Counter (if yes, please list)	

SECTION III 3-4; Maximum Score is **24**.	Individual's Total Medication Issues Score (for items 3-4)

5. In the past 6 months have you seen a doctor (or physician's assistant, nurse practitioner)? Been admitted to the hospital? Gone to the emergency room? *There is **no score** for this question.*

Medical Utilization/ Hospitalization
❑ Yes ❑ No ❑ Don't know
Dr.'s Name:
Admission Date:
Discharge Date:
Name of Facility:
Reason:

6. Have you ever been a resident of a nursing home or similar place? *There is **no score** for this question*

Medical Utilization/ Nursing Home
❑ Yes ❑ No ❑ Don't know
Admission Date:
Discharge Date:
Name of Facility:
Reason:

7. Do you have or need any of the following special equipment, devices, or aids? *There is **no score** for this question.*

Special Equipment				
Prosthesis (Type)	No	Has & uses	Has, but does not use	Needs, but does not have
Cane	❑	❑	❑	❑
Walker	❑	❑	❑	❑
Wheelchair	❑	❑	❑	❑
Brace (leg/back)	❑	❑	❑	❑
Hearing Aid	❑	❑	❑	❑
Glasses	❑	❑	❑	❑
Contact lenses	❑	❑	❑	❑
Dentures	❑	❑	❑	❑
Emergency Alert Response	❑	❑	❑	❑
Bedside commode	❑	❑	❑	❑
Bathing equipment	❑	❑	❑	❑
Prosthesis (Type)	No	Has & uses	Has, but does not use	Needs, but does not have
Transfer equipment	❑	❑	❑	❑

Hospital bed	❑	❑	❑	❑
ADL adaptive equipment	❑	❑	❑	❑
Adaptive eating equipment	❑	❑	❑	❑
Disposable medical supplies	❑	❑	❑	❑
Communication Devices	❑	❑	❑	❑
Physical therapy	❑	❑	❑	❑
Occupational therapy	❑	❑	❑	❑
Speech therapy	❑	❑	❑	❑
Other (specify)	❑	❑	❑	❑

8. Ask the following questions about alcohol use. Score 1 for each "yes" answer.

Alcohol Use		
During the past year, did you drink any alcoholic beverages, including beer and wine?	❑ Y (1)	❑ N (0)
During the past year did anyone else think you use alcohol?	❑ Y (1)	❑ N (0)
During the past year, on average, counting beer, wine and other alcoholic beverages, how much did you drink? (amount and frequency)	Amount:	Frequency:

9. Ask the following questions about tobacco use. Score 1 for each "yes" answer.

Tobacco Use		
During the past year did you smoke or use tobacco?	❑ Y (1)	❑ N (0)
During the past year, did anyone else think you use tobacco?	❑ Y (1)	❑ N (0)

10. Ask the following questions about drug use. Score 1 for each "yes" answer.

Illegal Drug Use		
During the past year, did you use illegal substances (drugs)?	❑ Y (1)	❑ N (0)
During the past year, did anyone else think you use illegal drugs?	❑ Y (1)	❑ N (0)

11. **Do not ask the applicant. Interviewer or team answers.** How concerned are you about the client's alcohol use, substance use and/or careless smoking? Scores are as follows. (Please Circle).

Team Concern					
Score	Not Concerned (0)	Slightly Concerned (1)	Mildly Concerned (2)	Moderately Concerned (3)	Extremely Concerned (4)

SECTION III 8-11; Maximum Score is **10**.	Individual's Total Alcohol/ Tobacco Use Score (for items 8-11)

12. How is your appetite? *There is **no score** for this question.*

Appetite			
	Good	Fair	Poor
Check	❑	❑	❑

If fair or poor is checked: please briefly describe why:

13. Have you gained or lost a significant amount of weight in the last six months? 10 % change is significant. Score 2 if answer is "yes."

Weight Gain					
	No	Yes/ Score	Gain Amount	Loss Amount	Describe gain or loss
Check	❑ N (0)	❑ Y (2)			

Are you happy with your weight? (please describe):

_____

_____

14. Do you have any problems that make it difficult to eat? Score 1 if answer is yes.

Eating Problems			
For example, do you have:	Score		Comments/ Care Plan
Tooth and mouth problems	❑ Y (1)	❑ N (0)	
Swallowing problems	❑ Y (1)	❑ N (0)	
Nausea	❑ Y (1)	❑ N (0)	
Taste problems	❑ Y (1)	❑ N (0)	
Can't eat certain foods	❑ Y (1)	❑ N (0)	
Food allergies	❑ Y (1)	❑ N (0)	
Any other problems with eating	❑ Y (1)	❑ N (0)	

15. Are you on any special diets for medical reasons? What type of special diets are you on? Check any special diets (doctors prescribed recommendation). Score 1 point for each special diet. **Maximum score of 2.**

Special Diets			
Diet	Score		Comments/ Care Plan
Low sodium (salt)	❑ Y (1)	❑ N (0)	
Low fat	❑ Y (1)	❑ N (0)	
Low sugar	❑ Y (1)	❑ N (0)	
Low cholesterol	❑ Y (1)	❑ N (0)	
Calorie supplement	❑ Y (1)	❑ N (0)	
Low calorie	❑ Y (1)	❑ N (0)	
Other	❑ Y (1)	❑ N (0)	
Total Score (**max 2 points total**)			

16. Is there anything else that we need to know that makes it difficult for you to eat properly? ***No score.***

❑ Yes

❑ No

Describe: _____

SECTION III 13-15 ; Maximum Score is **11**.	Individual's Total Nutrition Score (for items 13-15)

17. Overall, do you consider your health as: (Score as follows)

Overall Health				
Score	Excellent (0)	Good (1)	Fair (2)	Poor (3)

If fair or poor are checked, please briefly describe why:

_____

_____

18. Do you have any new health problems? *There is **no score** for this question.*

Describe:

SECTION III 17 ; Maximum Score is **3**.	Individual's Total Health Evaluation Score (for item 17)

Comments on Health Assessment:

Brain Injury Waiver Comprehensive Assessment Form
Functional Assessment (ADLS)

SECTION IV
A. Functional Assessment

Address all questions to the client, if possible. The purpose of these questions is to determine actual *ability* to do various activities. Sometimes care givers help the client with an item regardless of the person's ability. Ask enough questions to make sure the client is telling you what he/she can or cannot do.

Response Scale:

0 points: No help. Client needs no help to perform any part of the activity.
2 points: Some help. Client needs physical help, reminders, or supervision during part of the activity.
3 points: Can't do it at all. Client cannot complete the activity without total physical assistance.

Activities of Daily Living (please check score)				
	Score			Comments
1. **Dressing** (Includes getting out of clothes and putting them on, fastening them and putting on shoes.)	❑ (0)	❑ (2)	❑ (3)	
2. **Grooming** (Includes combing hair, washing face, shaving, and brushing teeth.)	❑ (0)	❑ (2)	❑ (3)	
3. **Bathing** (Includes running water, taking a bath or shower, washing all parts of the body, including hair.)	❑ (0)	❑ (2)	❑ (3)	
4. **Eating** (Includes eating, drinking from a cup, and cutting foods.)	❑ (0)	❑ (2)	❑ (3)	
5. **Transferring** (Includes getting in and out of a bed or chair.)	❑ (0)	❑ (2)	❑ (3)	
6. **Walking/ Mobility** (Includes walking around with a cane or walker, using a wheelchair. Ability to walk short distances. Does not include stair climbing.	❑ (0)	❑ (2)	❑ (3)	
7. **Climb Stairs** (Ability to use stairs safely.)	❑ (0)	❑ (2)	❑ (3)	
8. **Toileting** (How well can you manage using the toilet? Using the toilet includes adjusting clothing, getting onto and off of the toilet, and cleaning up after using the toilet. If accidents occur and a person manages alone, count at independent. If reminders are needed to use the toilet, this counts as "some help.")	❑ (0)	❑ (2)	❑ (3)	
9. **Bladder/ Bowel Control** (How well can you control your bladder or bowel?) Seldom has accident- score 0 Occasionally has an accident (less than 6 mo)- 2 Monthly accidents- score 3 Weekly accidents- score 4	❑ (0)	❑ (2)	❑ (3)	❑ (4)
10. Does client wear incontinent briefs? ***No Score***				
11. If yes, do you need help changing them? Score	❑ (0)	❑ (2)	❑ (3)	

0-3 depending on the amount of help needed to use them.	none	weekly	daily	
SECTION IV A 1-11, Max score **31**. Total ADL Score:				

B. Instrumental Activities of Daily Living (IADLs)

Address all questions to the client, if possible. The purpose of these questions is to determine actual *ability* to do various activities. Sometimes care givers help the client with an item regardless of the person's ability. Ask enough questions to make sure the client is telling you what he/she can or cannot do.

Response Scale:

0 points: No help. Client needs no help to perform any part of the activity.
2 points: Some help. Client needs physical help, reminders or supervision during part of the activity.
3 points: Can't do it at all. Client cannot complete the activity without total physical assistance.

Instrumental Activities of Daily Living (please check score)				
	Score			Comments
1. **Answering the telephone** (Includes the use of an amplifier or special equipment.)	❑ (0)	❑ (2)	❑ (3)	
2. **Making a telephone call** (Includes ability to call on the phone.)	❑ (0)	❑ (2)	❑ (3)	
3. **Shopping** (Includes shopping for food and other things you need, but *does not* include transportation.)	❑ (0)	❑ (2)	❑ (3)	
4. **Transportation ability** (Includes using local transportation or driving places beyond walking distances.)	❑ (0)	❑ (2)	❑ (3)	
5. **Prepare meals** (Includes preparing meals for yourself, including sandwiches, cooked meals and TV dinners.)	❑ (0)	❑ (2)	❑ (3)	
6. **Laundry** (Includes doing laundry, including putting clothes in the washer or dryer, starting and stopping the machine and drying the clothes.)	❑ (0)	❑ (2)	❑ (3)	
7. **Light housekeeping** (Includes dusting, vacuuming, sweeping, etc. Does not include laundry.)	❑ (0)	❑ (2)	❑ (3)	
8. **Heavy chores** (Includes yard work, windows, moving furniture, but does not include laundry.)	❑ (0)	❑ (2)	❑ (3)	
9. **Taking medication** (Ability to take your own medication.)	❑ (0)	❑ (2)	❑ (3)	
10. **Managing money** (Includes managing your own money, paying bills, balancing a checkbook.)	❑ (0)	❑ (2)	❑ (3)	
SECTION IV B 1-10, Max score **30**. Total IADL Score:				

Comments on ADL/IADL scores:

Brain Injury Waiver Comprehensive Assessment Form
Social Resources

SECTION V
A. Social Resources

1. Do you live alone? Score 2 points if "Yes."

Score	❑ Y (2)	❑ N (0)

2. Do you have someone who could stay with you for a while if you needed it, or if you were sick? Score 2 points if "no." If yes, fill in information below.

Score	❑ Y (0)	❑ N (2)

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ - _____

3. If you could no longer live in your present location, do you have any thoughts about where you would like to live? ***No Score***.

	Check
Home	❑
Smaller home (apartment, mobile home)	❑
Relative's home (specify):	❑
Board and care home	❑
Nursing home	❑
Other (specify):	❑
Don't know	❑

4. Do you have someone you can talk to when you have a problem? Score 2 points if "No." Fill out information below if "Yes."

Score	❑ Y (0)	❑ N (2)

Name: _____
Relationship to client: _____

5. Do you have a pet? ***No score.***

❑ Yes
❑ No

6. How many times do you talk on the telephone to friends, relatives or others during a week? Score as follows. *Select only one*

	Score
Daily	❑ (0)
2-6 times a week	❑ (1)
Once a week	❑ (1)
Less than once a week	❑ (2)
I do not have a phone	❑ (2)
I'm not sure how to answer this question.	❑ (2)
Maximum points for #6 is 2. Total Score	

7. How many times during a week do you spend time with someone who does not live with you? Do you go to see them or do they come to visit you? Do you do things together? Score as follows. *Select only one*

	Score
Daily	❑ (0)
2-6 times a week	❑ (1)
Once a week	❑ (1)
Less than once a week	❑ (2)
I do not have a phone	❑ (2)
I'm not sure how to answer this question.	❑ (2)
Maximum points for #7 is 2. Total Score	

8. What activities do you enjoy (***no score***)?

_____
_____
_____
_____

9. If you want to attend religious services or other community groups, are you able to attend as often as you like?

❑ Yes
❑ No

SECTION V, 1-2, 4, 6-7. Max score is **10**.	Individual's Social Resources Score (for items 1-2,4,6-7)

Comments on social resources:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Brain Injury Waiver Comprehensive Assessment Form
Social Resources

SECTION VI
A. Mental Health

1. Are you currently or have you received mental health services or counseling? ***No score***. If yes, complete information below.

❑ Yes
❑ No
Name of agency or therapist:
_____
Comments:
_____

2. **Do not ask the applicant. Interviewer or team answers.** Does the client….? ***No score***.

	Yes	No
Appear to be depressed, lonely or dangerously isolated?	❑	❑
Wander away from home or other places for no apparent reason?	❑	❑
Need supervision? (If yes, specify how much) _____	❑	❑
Pose a danger to self or others?	❑	❑
Demonstrate significant memory problems?	❑	❑
Other (specify):	❑	❑

3. **Do not ask the applicant. Interviewer or team answers.** Does the client require….? ***No score.***

	Yes	No
Mental health assessment	❑	❑
Mental health referral	❑	❑

Behavior/ Emotional Deficits		
The following scale is used to assess the frequency of the applicant's behavioral problems. Please write in the scores for questions 4-10. Descriptions of behaviors must be included. **Note: Please refer to the manual to identify the descriptions for each function listed below**		
0	Absent	No behavior problem
1	Rarely	Less than once a month
2	Occasionally	At least once month, but not weekly
3	Frequently	More than once a week, but not daily
4	Daily	On a daily basis
5	Hourly	Continuously throughout the day

4. Self Injurious Behavior Score: _____

Describe:_____

_____

_____

5. Hurtful to Others Score: _____

Describe:_____

_____

_____

6. Destruction to Property Score: _____

Describe:_____

_____

_____

7. Socially Offensive Behavior Score: _____

Describe:_____

_____

_____

8. Wandering Score: _____

Describe:_____

_____

_____

9. Withdrawal Score: _____

Describe:_____

_____

_____

10. Susceptibility to Victimization Score: _____

Describe:_____

_____

_____

SECTION VI 4-10. Max score is **35**.	Individual's Mental Health/ Behavioral Score (for items 4-10)

Brain Injury Waiver Comprehensive Assessment Form
Control of Emotions

SECTION VII

Ask: Brain Injury often effects people emotionally. Since your Brain Injury have you had difficulty with any of the below listed consequences? *No Score.* Level of Severity will only be marked if "Post BI" is checked "yes."

Important Instructions (see appendix of CBIA manual)

Psychological Consequences	**Post BI (check)**	**Severity (circle)**
Impaired sense of self *(self esteem)*	❑ Y ❑ N	M O S
Fear of loss of control	❑ Y ❑ N	M O S
Easily agitated or irritated	❑ Y ❑ N	M O S
Easily startled	❑ Y ❑ N	M O S
Feelings of paranoia *(suspicious/ distrusting others)*	❑ Y ❑ N	M O S
Spells of terror or panic	❑ Y ❑ N	M O S
Feelings of depression	❑ Y ❑ N	M O S
Feelings of shame or guilt	❑ Y ❑ N	M O S
Persistent anxiety	❑ Y ❑ N	M O S
Anxiousness or feelings of fear and dread	❑ Y ❑ N	M O S
Feelings of discouragement	❑ Y ❑ N	M O S
Withdrawal or social isolation	❑ Y ❑ N	M O S
Feeling others not appreciating your difficulties	❑ Y ❑ N	M O S

Feeling everything is an effort	❑ Y ❑ N	M O S
Feeling inept or worthless	❑ Y ❑ N	M O S
Laughing or crying without apparent cause	❑ Y ❑ N	M O S
Worrisome thoughts won't leave your mind	❑ Y ❑ N	M O S
Reliability Check		
1) Diminished insight *(understanding/ awareness of own deficits)* *please compare with response from (Section II, Cognitive Deficits, Item 9)*	❑ Y ❑ N	M O S
2) Making up explanations for things *(confabulation)* *please compare with response from (Section II, Cognitive Deficits, Item 11)*	❑ Y ❑ N	M O S
3) Insensitive/aggressive to others and social setting *please compare with response from (Section VI, Behavior/ Emotional Deficits, Item 7)*	❑ Y ❑ N	M O S

Brain Injury Waiver Comprehensive Assessment Form
Employment

SECTION VIII

Ask: Brain Injury often effects people in the work environment. Since your Brain Injury have you had difficulty with any of the below listed issues? *No Score*.

Level of Severity will only be marked if "Post BI" is checked "yes."

Important Instructions for this section: (see appendix of CBIA manual).

Employment Questionnaire:	**Post BI (check)**	**Severity (circle)**
Do you have difficulty remembering job tasks?	❑ Y ❑ N	M O S
Do have difficulty remembering new information?	❑ Y ❑ N	M O S
Do you have difficulty beginning (initiating) job activities/tasks?	❑ Y ❑ N	M O S
Do you oftentimes not feel interested or motivated in performing your tasks?	❑ Y ❑ N	M O S

Do you have difficulty with organizing yourself and to develop a simple plan on how to complete your tasks?	❑ Y ❑ N	M O S
Do you have difficulty making decisions?	❑ Y ❑ N	M O S
Do you have a hard time getting along with co-workers and superiors?	❑ Y ❑ N	M O S
Do you have difficulty remaining calm in stressful situations?	❑ Y ❑ N	M O S
Do you know what your strengths and weaknesses are?	❑ Y ❑ N	M O S
Do you have difficulty with sequencing?	❑ Y ❑ N	M O S

Is the applicant currently undergoing Vocational/ Occupational Rehabilitation?

_____

_____

_____

_____

Brain Injury Waiver Comprehensive Assessment Form
Scoring Matrix

SECTION IX

Please fill out the matrix below with the total scores from the sections in the assessment. Add the total scores. Eligibility falls between the scores of **40-120**. This matrix is to be used for three consecutive years, after which a new assessment form will be completed for SECTIONS II through VI. SECTION I only changes as necessary. Please have the individual and/or his or her guardian sign the assessment for each year, along with the signature of the ABI support coordinator.

Comprehensive Assessment/ Re-assessment Scoring Matrix			
Area	Section		Score
		Maximum score	
Cognitive Functioning (MSQ)	SECT II #1-6	28	
Cognitive Deficits	SECT II #7-11	30	
Medication Issues	SECT III #3-4	24	
Alcohol/ Tobacco Use	SECT III #8-11	10	
Nutrition	SECT III #13-15	11	
Health Evaluation	SECT III #17	3	
ADLs	SECT IV A #1-11	31	
IADLs	SECT IV B #1-10	30	
Social Resources	SECT V #1-2, 4, 6-7	10	
Mental Health/ Behaviors	SECT VI #4-10	35	
	Total Score (40-120)		

Signatures:

Date: _____ ABI Support Coordinator/ Intake Worker:

Print Name: _____

Signature: _____

Client: _____

Guardian/Parent/Other: _____

Comments:

_____

_____

_____

_____

Keys:

Yellow:	Questions the ABI Support Coordinator will ask the consumer. Please refer to the accompanying Intake Screening and Assessment Form Manual.
Red Border:	Questions asked/answered to/by others (Interviewer, family, provider, etc)
Blue:	Scoring fields
Green:	PART Max. Scores.
Shaded Grey:	Questions that are not scored (not valid for determination of eligibility score)
Purple:	**Section VII and VIII**
Pink:	Total End Score