Utah Department of
Health & Human Services
Services for People with Disabilities

CRITICAL NEEDS ASSESSMENT

Physical disabilities waiver

Form: 3-2
Version: 5/2024

Part A - To be completed by the applicant

Applicant's personal information

Name:	Date of birth:	Over 18 Yes No	
Address:	City:	State:	Zip:
Social security number:	Home phone: Cell phone:	Work phone: E-mail:	
Present living situation: House Apartment Nursing home Other (explain)			

Description of Disability:
In order to qualify for Physical Disabilities Services, you must have a physical impairment that has resulted in the functional loss of two or more limbs. Please describe the nature of your disability:

Is this condition: Temporary Permanent	Date of onset:

If your disability is temporary, what is the expected duration of the disability?

Do you have a Medicaid card? Yes No Pending	What is your gross monthly income?

Do you currently receive home health aide services? Yes No If so, how often?
Do you currently have a personal attendant *not from a home health agency?* Yes No
If so, how often?
What is the name of your personal attendant (if you have indicated you have one?)

Please indicate the activities of daily living you require assistance with (check all that apply):

Dressing	Grooming	Cooking
Eating	Laundry	Grocery shopping

Assistance/support to transfer to or from a bath/shower or a transportation vehicle

Assistance with tasks/services such as ventilator, catheter care, suctioning or overnight attention

Please describe your expectations of how this program will help you:

Applicant's verification

Dear applicant:
Physical Disabilities Services may only be delivered through the self-administration method. This method supports an individual with a disability in self-directing the personal assistance services they receive through the Physical Disabilities program.

This means that you need to be aware that:

a) You are the employer, taking responsibility for hiring and managing your own personal attendants which includes responsibility for employee selection, scheduling, termination, performance evaluations, arranging back-up coverage, and submitting time sheets. Consumer Preparation Service, a preparatory service providing instructions for these tasks, is available through your Nurse Coordinator.

b) You must be able to instruct your personal attendants on many levels including how and when you need assistance, changing levels in personal needs, grievance procedures, emergency coverage, exploitation, and abuse.

This application is intended to point out any issues of concern or deficits that may prevent you from operating the program safely and efficiently.

I certify that the information provided in this application is true and accurate. I also agree to comply with all program requirements.

Applicant's signature: _____ **Date:** _____

Comments:

Return Completed Form to:
Division of Services for People with Disabilities
Attn: Nurse Coordinator
195 North 1950 West
Salt Lake City, UT 84116

FOR DIVISION OFFICE STAFF ONLY
STAMP DATE RECEIVED IN BOX

Part B - To be completed by the physician

Physician's name:	Phone:		
Address:	City:	State:	Zip:

Physician's recommendations:

SECTION I: DIAGNOSTIC INFORMATION

Dear Physician:
Your patient is applying for Physical Disabilities Services through the Division of Services for People with Disabilities (DSPD). Physical Disabilities Services means hands-on care, of both a medical (to the extent permitted by State law) and non-medical services of a supportive nature, specific to the needs of an adult with a physical disability (assistance with activities of daily living and personal care). Please take a few minutes to complete this page. The information you provide will assist the DSPD Nurse Coordinator in making a determination of whether your patient is eligible for service.

Name of patient:

Patient's diagnosis:
ICD 10 Code: _____ Definitions:_____

In order to qualify for Physical Disabilities services, the applicant must meet all of the following criteria. Please mark yes or no to each of these statements based on your professional judgment.

Patient is medically stable Yes No If "no", please explain below:

Patient has functional loss of two or more limbs. Yes No If "no", please explain below:

The loss of two or more limbs is permanent. Yes No If "no", please answer next question

Applicant's functional loss of two or more limbs is expected to last at least 12 months or more.
Yes No If No, please explain below:

SECTION II: SELF-ADMINISTERED ASSESSMENT

Note to Physician:
Self-administration is a service delivery method that supports an individual with a disability in self-directing the personal assistance services they receive through the Physical Disabilities program. Physical Disabilities Services may only be delivered through the self-administration method.

This means that in order to be eligible for Physical Disabilities Services, your patient must be able to:

a) Direct certain aspects of the patient's care. For example, they must have the ability to hire, train and supervise their own personal attendant(s) and determine how and when services are provided; and

b) Self-administer, which means being aware of his/her needs and having the ability to instruct the personal attendant as to how and when assistance is needed.

If you have concerns about your patient's ability to complete these tasks, please state them in the "Comments" section below. This assessment is intended to determine any issues of concern or deficits that may interfere with the patient's ability to self-direct the Physical Disabilities Services needed. Feel free to engage your patient in an open dialogue while going through parts (a) and (b) directly above.

I certify that the patient, based on the assessment above:

Is able to self-administer their program.

Is **not** able to self-administer their program.

Comments:

I certify that the information I have provided under sections I and II in this application is true and accurate to the best of my knowledge.

Physician's signature: _____ Date: _____

Additional comments:

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