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

CRITICAL NEEDS ASSESSMENT

Physical disabilities waiver

Form: 3-2
Version: 5/2024

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:
(Check all that apply)

- Attendant
- Personal response system
- consumer preparation
- liaison

Supports currently received:
(Check all that apply)

- Home health/CNA
- Medication management
- Residential
- Other

Desired/needed services:
(Check all that apply)

- Physical disability cause
- Date of onset
- Paraplegia
- MS
- Neurological
- Mental illness
- Deafness
- Blind
- 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:** (score range 0 to 10)

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

_____ **3. Protective service issues** (score range 0 to 9)

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

_____ **4. Projected deterioration issues:** (score range 0 to 9)

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

_____ **5. Resources/supports needed:** (score range 0 to 10)

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?

_____ **6. Time on the waiting list:** (score range 0 to 10)

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)

_____ **7. Functional status:** (score range 0 to 54)

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.

Functional status/activity	Rating			
1. In/our of bed	0	1	2	3
2. In/out of chair	0	1	2	3
3. Toileting	0	1	2	3
4. Bathe	0	1	2	3
5. Groom	0	1	2	3
6. Dress/undress	0	1	2	3
7. Drink/eat	0	1	2	3
8. Take medication	0	1	2	3
9. Mobility in home	0	1	2	3
10. Use telephone	0	1	2	3
11. Prepare meals	0	1	2	3
12. Dishes	0	1	2	3
13. Clean House	0	1	2	3
14. Laundry	0	1	2	3
15. Admit visitors	0	1	2	3
16. Manage finances/mail	0	1	2	3
17. Socialize	0	1	2	3
18. Communicate	0	1	2	3

Rating

0 = Independent with or without devices

1 = Minimal assistance

2 = Moderate assistance

3 = Cannot accomplish

Total Score_____

_____ **Total score:** (100 points possible)

Nurse coordinator: Date:

Nurse coordinator: Date: