**Assessment**

# **COMMUNICATION**

## Expressing Yourself and Understanding Others

|  |
| --- |
| **How does the person communicate?** *Consider speech, vocalizations, nonverbal cues, sign language, use of a device, writing skills, etc.* |
|  |
| **What are the ways the person lets others know their likes, dislikes, and/or what is on their mind?** *Consider writing, singing, dancing, laughing, crying, silence, movement, stillness, etc.* |
|  |
| **How does the person ask for help? Are there important cues?** |
|  |
| **How does the person want or need others to communicate with them?** *Consider use of calm voice, eye contact, having face visible to read lips, words to avoid, allowing time to process, repeating information, written communication, need for interpreter or assistive device, etc.* |
|  |

## Communication Chart (add additional lines as needed)

|  |  |  |
| --- | --- | --- |
| What the person does or says: | What it usually means: | What we should do/say in response: |
|  |  |  |
|  |  |  |
|  |  |  |

## Communication Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
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|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |  |
| --- | --- | --- | --- |
| Speech Evaluation | Technology Assessment | Other |  |

# **ADVOCACY & ENGAGEMENT**

## Valued Roles and Making Choices

|  |
| --- |
| **What are the person’s strengths?** *What is the person good at? How would the person like others to think of or describe them? Does the person help others speak up for themselves?* |
|  |
| **What has the person accomplished that they are proud of?** |
|  |
| **What does the person want to accomplish?** *Consider short- and long-term goals. Does the person have adequate resources available? Do they want to accomplish this goal on their own or do they need supports? Could this be a potential outcome?* |
|  |
| **Is the person able to make their own decisions?**   * **If yes:** *Is there anything important to the person that the team needs to know?* * **If no:** *What are the barriers?*   *What types of choices does the person make daily? How does the person communicate and express their decisions and opinions? How can the team empower the person to make decisions more independently?* |
|  |
| **If the person needs help to make a decision how would they get it? Who would they ask?** *How does the person problem solve or advocate?* |
|  |
| **Does the person feel others support them and their decisions?** |
|  |
| **Does the person wish they could make more decisions by themselves?** *Does the person want to participate in training and/or hiring of staff? How do they make decisions about their day to day life? How do they make decisions about impactful situations? Is the person able to participate in groups and activities they want? Do they choose the places they visit and who they spend time with?* |
|  |

## Responsibility and Leadership

|  |
| --- |
| **Does the person understand making decisions that may result in a negative or legal consequence?** *Would education, counseling, or additional support help the person understand negative or legal consequences?* |
|  |
| **If the person is of transition age, do they need help to understand/prepare for additional rights as an adult? If so, please explain.** *Consider bedtimes, social media access, privacy regarding health issues, and/or personal choices.* |
|  |
| **If the person is of transition age, do they understand consequences and responsibilities associated with being an adult?** *Consider voting, laws, law enforcement, etc.* |
|  |
| **Does the person understand their rights? If so, do they understand what to do when their rights are violated?** |
|  |
| **Does the person ever feel forced to do something they do not want to do? If so, how do they respond?** |
|  |
| **Does the person have interest in being actively involved in voting, government activism, etc.?** *What support would they need?* |
|  |

## Advocacy & Engagement Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
|  | |

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|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |  |
| --- | --- | --- | --- |
| Criminal Court Order | Technology Assessment | Other |  |

# **SAFETY & SECURITY**

## Safety and Emergency Skills

|  |
| --- |
| **Does the person know what to do in an emergency?** *Consider emergencies such as fires, tornadoes, strangers, crime, power outages, car accidents, first aid, etc.* |
|  |
| **What safety skills does the person possess?** *How does the person keep safe at home and in the community? Can the person safely carry and use a key to lock/unlock door? Is the person at risk for exploitation?* |
|  |

## Behavioral Well-being

|  |
| --- |
| **Does the person exhibit any behaviors that are a risk of harm to themselves or others? If so, please explain.** |
|  |
| **Does the person exhibit any behaviors that would present a likelihood of legal sanction?**  **If so, please explain.** |
|  |
| **Does the person exhibit any behaviors that require a specifically structured environment or cause them to live in a more restrictive setting? If so, please explain.** |
|  |

## Emotional Well-being

|  |
| --- |
| **Is the person happy/satisfied with their life?** |
|  |
| **What makes the person happy? Is the person able to do what makes them happy and/or what they enjoy?** *Consider hobbies, interests, etc.* |
|  |
| **What is the best thing that ever happened to the person?** |
|  |
| **What does the person believe would make their life better?** |
|  |
| **Does the person exhibit a pattern of withdrawal, apathy, or lack of energy which is not attributed to injury or illness?** |
|  |
| **Does the person have people in their life that they can communicate with when feeling upset or worried? If so, who?** |
|  |
| **What self-help skills does the person use when upset or worried?** |
|  |
| **Does the person feel safe and secure?** *When and where? What sort of things help them feel safe?* |
|  |
| **What causes the person to feel isolated, afraid, or powerless?** *Consider people, places, things, etc. Assume trauma history; if known, please explain.* |
|  |
| **What makes the person’s typical day better?** *Consider at home, at work, mealtime, weekend, holidays, etc.* |
|  |
| **What makes the person’s typical day worse?** *Consider at home, at work, mealtime, weekend, holidays, etc.* |
|  |

## Supervision Considerations

|  |
| --- |
| **SSA/QIDP Only: What are the results of applicable pre-assessments?** *Consider the results of pre-assessments: Level of Care, OEDI, COEDI, etc.*  **Levels of Supervision and Definitions:**   1. **No Paid Supports:** The person can be alone and does not require any paid/remote support to ensure safety for (time frame). 2. **General:** Staff must be able to hear/contact the person if they called for help, and respond within a few minutes. 3. **Auditory:** Staff must be able to hear the person if they called for help and respond quickly. 4. **Visual:** Staff must be able to see the person and be able to provide support or direction. 5. **Close & Constant:** Staff may never leave the person, and must always be able to respond immediately. 6. **Technology:** Describe technology solutions in conjunction with levels 1-5. |
|  |

## Safety & Security Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
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|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |
| --- | --- | --- |
| Technology Assessment | Other: |  |

# **SOCIAL AND SPIRITUALITY**

## Personal Networks, Activities, and Faith

|  |
| --- |
| **Does the person belong to any clubs, groups, or organizations? Where do they hang out/meet people?** *Consider volunteering, community, religious, addiction services, support groups, etc. Does the person feel welcome there? When and how often do they go there? How does the person get there?* |
|  |
| **What cultural considerations are important to the person?** *Consider family traditions, customs, activities, stories, faith, heritage, rituals, celebrations, holidays, food, clothing, books or literature, items, planning for end of life, etc****.*** *Are there any barriers to the person participating in these? If so, please explain.* |
|  |
| **Does the person know how to find new and interesting activities?** |
|  |

## Friends and Relationships

|  |
| --- |
| **Who is important in the person’s life?** *Who is the person’s favorite person? What does the person like about them? What do they do together? How did the person meet them? Consider therapist, support groups, sponsor, etc. in addition to the usual natural supports and paid service providers.* |
|  |
| **Have there been significant changes in any relationships with people important to the person?** |
|  |
| **How does the person stay in touch with people in their life?** *Does the person need assistance to communicate with friends and family? Does the person use social media? If so, does the person need/want help using it? Consider how they maintain devices, access/use social media, and if they have knowledge of online safety skills.* |
|  |
| **Does the person visit with family and friends?** *What opportunities does the person have to spend time with these people?* |
|  |
| **What activities does the person do with friends/family?** *How often?* |
|  |
| **Are there things that get in the way of the person having relationships or making friends?** *Consider trauma and/or broken relationships.* |
|  |
| **Does the person understand the differences in relationships?** *Consider relationships with friends, coworkers, supervisors, family, paid staff, etc.* |
|  |
| **Is the person dating/in a relationship?** *What is their marital status? Is the person interested in dating/intimacy? Does the person have the opportunity to meet potential partners? Consider if the individual would like to share details about their sexual orientation. Does the person have the opportunity and privacy for intimacy? Does the person feel safe in their relationship?* |
|  |
| **Does the person have opportunities to go out on dates? If no, what are the barriers?** |
|  |

## Social & Spirituality Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
|  | |

|  |
| --- |
|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sexual Risk Assessment | Social Work Plan | Technology Assessment | Other: |  |

# **DAILY LIFE AND EMPLOYMENT**

## School/Education and Ongoing Learning

|  |
| --- |
| **Is the person currently in school?** *Consider transitions, college, etc. What does the person like or not like about their current program? Does the person like their teachers/instructors? What school activities/subjects does the person like? Does the person want to further their education? If no, explore what the person wants to spend time doing during the day, where and how they want to spend their day. Focus on new skills, utilizing talents and strengths. What kind of transition planning is in place? Does the person want to further their education?* |
|  |
| **Does the person have any challenges at school?** *What are the barriers? What does the person need available to learn? Does the person use specific equipment at school?* |
|  |
| **What might the person want to learn how to do and how do they want to learn it?** *Is the person interested in taking courses or attending trainings? What kinds of community-based work experiences have they had?* |
|  |
| **What are the strategies that help the person learn?** *Consider video, audio, hands-on, etc.* |
|  |

## Employment

|  |
| --- |
| **Does the person have a job? If yes, Is the person working in this job without any paid supports?** *What* *is their job? Do they like it? What tasks do they enjoy or not enjoy? Do they make enough money? Is the person working as much as they want? Does the person want a different job or want to advance? How does the job match the person’s desires, strengths, and interests?* |
|  |
| **Does the person want a job? If yes, please explain.** *Consider type, location, support, etc. Does the person have any paid or unpaid work experience? Consider what the person liked or disliked. Have they previously received services from outside agencies to assist with finding employment? Have they accessed supports like Job Development or Job Coach? What worked and did not work? Are there barriers (transportation, finances, etc.) to the person getting a job? Do they have a resume? Does the person know what a job is and what it entails? Do they understand the connection between working and making money?* |
|  |
| **How does the person learn/work best?** *Does the person prefer working alone, with one person, in a small group, or in a large group? When does the person feel most independent? How does the person learn best? What type of work environment does the person prefer (hot/cold, dark/light, early/late, noisy/quiet, etc.)?* |
|  |
| **Does the person have any challenges at work?** |
|  |

## Finance

|  |
| --- |
| **How does the person make money?** *What would improve their ability to increase income?* |
|  |
| **Does the person receive any benefits?** *Consider SSI, SSDI, trust fund, food assistance, Medicaid, Medicare, rental assistance, etc. How much? Does the person have an authorized representative and/or payee? If so, who?* |
|  |
| **Does the person regularly have to spend down money to keep their Medicaid/SSI benefits? If yes, please explain.** *Have they explored saving money (i.e., a STABLE account, Medicaid Buy-In, trusts, etc.)?* |
|  |
| **Does the person need help reporting wages? If yes, please explain.** |
|  |
| **What control does the person have with their money?** *How much money is the person able to safely carry? Do they feel they have access to their funds or want more control over their money? Do they value money? Do they have a debit or credit card? Are there supports needed for them to carry money?* |
|  |
| **Does the person understand how to use their money?** *How does the person decide what they will buy and how much they will spend? Are they able to return items? Do they know about credit reports?* |
|  |
| **Is the person able to take care of their finances?** *What kind of support does the person need to manage money (i.e., bills paid on time, budgeting, taxes, etc.)? Do they need help due to a risk of exploitation?* |
|  |
| **Does the person have the things they need?** *Consider the person’s ability to access personal belongings and/or if technology or other items are needed to enhance their lives. Do they need an inventory of their items?* |
|  |
| **What is the person's plan for life beyond employment?** *Does the person need to maintain a certain level of financial security to ensure quality of life during retirement? Are they living in a situation that is conducive to aging or financially feasible once in retirement? Do they have end of life plans in place, or would they want to begin planning for their end of life wishes? Consider if the person's community, culture, religion, etc. will affect retirement and end of life planning.* |
|  |

## Daily Life & Employment Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
| Place on path to community employment (select one):  (1) Person has a job, may be interested in a different one or moving up  (2) Person wants a job and needs help to find one  (3) Person isn’t sure about work and may need to learn more  (4) Person doesn’t think they want to work, but may not know enough about it | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
|  | |

|  |
| --- |
|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |
| --- | --- | --- |
| Technology Assessment | Other: |  |

# **COMMUNITY LIVING**

## Life at Home

|  |
| --- |
| **Where and with whom does the person live? *Do they live alone, with a spouse, one parent, two parents, with other family members, shared living, with 1-3 others (non-related), with 4 or more (non-related)?*** |
|  |
| **Does the person want to explore other living arrangements?** *Consider different roommate(s), living more independently, living on their own, different neighborhood, etc.* |
|  |
| **Does the person feel they have access to all areas of their home?**   * **If yes:** *Do they require supports, adaptive equipment, technology, modifications, etc.?* * **If no:** *What are the barriers?* |
|  |
| **Does the person have specific items they value and/or have a close attachment? If so, please explain.** |
|  |
| **What contributions does the person like to make to their household?** *Consider certain decorations, cooking, cleaning, shopping, helping those they live with, etc.* |
|  |
| **Where does the person spend most of their time when they are at home?** |
|  |
| **What does the person like doing around the house?** *Consider what makes the person most happy, most content, and what makes life at home enjoyable. Consider what the person does not enjoy doing.* |
|  |
| **Does the person need help with chores around their home?**   * **If yes:** *What type?* * **If no:** *What has been the person’s favorite job or work around the house?* |
|  |

## Getting Around

|  |
| --- |
| **Does the person safely and reliably get around?** *Consider home, work, during the day, community, other settings. How?* |
|  |
| **Are there certain areas and/or surfaces that are difficult to navigate? If so, please explain.** *Consider home, work, during the day, community, other settings.* |
|  |
| **What type of transportation is needed?** *Is a modified vehicle required? Consider home, work, during the day, community, other settings. Do they have a state ID or driver’s license?* |
|  |
| **Does the person feel they are able to access the community when they want and need? Please explain.** |
|  |
| **Does the person want to learn more about how to access the community with more independence? If yes, how?** *Consider staff support, 1:1, more alone time, etc. Can they travel in unfamiliar settings?* |
|  |

## Community Living Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
|  | |

|  |
| --- |
|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Occupational Therapy | | Assistive Technology | Emergency Response | Physical Therapy | Technology Assessment |
| Other: |  | | | | | |  |

# **HEALTHY LIVING**

## Medical and Dental Care

|  |
| --- |
| **What physical/health conditions/concerns should people know about?** *List developmental disability, medical, and mental health diagnoses. Consider health risks such as dehydration, constipation, allergies, etc. Are there cultural considerations for healthcare needs?* |
|  |
| **Has the person been to the hospital recently? If so, please explain.** *Was follow-up care recommended?* |
|  |
| **Does the person ever go see a doctor/dentist?** *Consider how the person gets to the appointment and any needed assistance (communication, understanding, sedation, etc.) before, during and after their appointment?* |
|  |
| **When the person is not feeling well, what do they do?** *Consider who and how they would alert someone.* |
|  |
| **Does the person need help making appointments?** *Consider transportation to and/or from the appointment, follow up, etc.* |
|  |
| **Does the person take medication?** **If so, please explain.** *Consider over-the-counter medications, prescriptions, PRN, etc.* |
|  |
| **Does the person need help with medication? If so, please explain.** *Based on assessment outcomes, what specific assistance or support is needed to complete safe, accurate medication administration (i.e., time reminders, a pre-filled caddy, tracking and support to get refills, etc.)?* |
|  |
| **Self-Administration Assessment(s)** ([Introduction/Instructions](https://dodd.ohio.gov/wps/wcm/connect/gov/e3b747dd-a7d2-4653-946a-d117f81586d0/Introduction-Instruction+Self-Administration+Assessment.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-e3b747dd-a7d2-4653-946a-d117f81586d0-n1vma34))  Click on specific link to access:   * [General/Oral and Topical Medication](https://dodd.ohio.gov/wps/wcm/connect/gov/df5a41ce-5a75-473f-a8b3-a40f48319c40/Self-Administration+Assessment+-+General.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-df5a41ce-5a75-473f-a8b3-a40f48319c40-mGZi4oc) * [G/J Tube](https://dodd.ohio.gov/wps/wcm/connect/gov/d3cd9e31-4434-4309-b5fe-b44017d75f14/Self-Administration+Assessment+for+G-J+Tube.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-d3cd9e31-4434-4309-b5fe-b44017d75f14-mGZl373) * [Glucometer](https://dodd.ohio.gov/wps/wcm/connect/gov/74cc5f1c-fbab-473d-a86e-6a9bb72d6af1/Self-Administration+Assessment+for+Glucometer.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-74cc5f1c-fbab-473d-a86e-6a9bb72d6af1-mGZhRsJ) * [Health-Related Activities](https://dodd.ohio.gov/wps/wcm/connect/gov/46438b11-64b7-4033-b606-b0992094d4c3/Self-Administration+Assessment+for+Health-Related+Activities.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-46438b11-64b7-4033-b606-b0992094d4c3-mGZhESD) * [Inhaled Medications](https://dodd.ohio.gov/wps/wcm/connect/gov/59f1d109-72a6-4e5c-8d46-fc136303236f/Self-Administration+Assessment+for+Inhaled+Medications.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-59f1d109-72a6-4e5c-8d46-fc136303236f-mGZiL-x) * [Oxygen Administration](https://dodd.ohio.gov/wps/wcm/connect/gov/e68ee69d-a110-47e7-981c-98a67bab6136/Self-Administration+Assessment+for+Oxygen.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-e68ee69d-a110-47e7-981c-98a67bab6136-mGZkos6) * [Insulin/Metabolic Glycemic Disorder Medications](https://dodd.ohio.gov/wps/wcm/connect/gov/a7591867-2928-44be-9e50-4a1e27400053/Self-Administration+Assessment-Insulin-Metabolic+Glycemic+Disorder+treatments.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-a7591867-2928-44be-9e50-4a1e27400053-mGZmfWH) |
|  |

## Nutrition

|  |
| --- |
| **Does the person need any special food or follow any kind of diet?** *Consider if a specialist has suggested the person follow a special diet (i.e., PWS, Diabetes, etc.). Does the person agree with and want to follow the recommendations?* |
|  |
| **What kinds of food does the person typically like to eat?** *Consider foods at home, work, community, etc.* |
|  |
| **Does the person require support before, during, and/or after a mealtime? If so, please explain.** *Consider g-tube, supervision and assistance while eating, adaptive equipment (specialized spoon, utensils, cup, plate, etc.).* |
|  |

## Wellness

|  |
| --- |
| **What does a healthy lifestyle mean to the person?** |
|  |
| **What are the person's hygiene and/or self-care routines?** *Consider showering, bathing, washing hair, brushing teeth, flossing, nail care, keeping clothes clean, sleep schedule, daily walk, time on social media, bedtimes, organizing personal space, listening to audiobooks, watching favorite show, cuddling with animals, relaxing at home, doing something fun, connecting with family/friends, etc.* |
|  |
| **Is the person interested in improving their healthcare habits in a specific area(s)?** *Consider beginning yoga, meditation, eating differently, accessing reproductive health services, specialized education/referral services. Are they curious about birth control or STI prevention? Do they have a safe person to discuss intimate matters and receive guidance in a way that supports their personal and cultural beliefs? Is transportation to clinics/support groups needed? Consider if trauma informs how the person approaches their health.* |
|  |

## Healthy Living Summary

|  |  |
| --- | --- |
| **Important To:** What makes the person feel satisfied, content | **Important For:** *Health, safety, valued member/social role* |
|  |  |
| **Skills & Abilities:** What is the person good at, what can they do on their own, what do they have to contribute | |
|  | |
| **Known & Likely Risks:** What is the risk, what does it look like, where does it occur?  *Consider any communication needs, medical needs, or behaviors that create a risk for the person in terms of immediate health & safety*, *risk of harm to self or others, or potential legal sanction that would need addressed in the person’s plan* | |
|  | |

|  |
| --- |
|  |

List technology solutions that have been explored (Detail solutions that may lead to supports that increase the person’s independence or note if no viable options):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No Support | Paid Support | Natural Support | Technology | Community Resource |
| Referral (OOD, etc.) | Potential Outcome |  |  |  |

## Specialized tools that require completion by a qualified professional:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| OT Evaluation | PT Evaluation | Nursing Assessment | Swallow Study | Psychological |
| Social Work Assessment | Behavioral Health Assessment (trauma history, diagnosis) | Physical Exam | Medical/ Dental/ Vision/ Ophthalmology | Technology Assessment |
| Other: |  | | | |

# **Working/Not Working \*Be sure to include technology solutions (add or delete lines as needed)**

|  |  |  |
| --- | --- | --- |
| **What’s Working** | **What’s Not Working** | **Who Said it?** |
|  |  |  |
|  |  |  |
|  |  |  |

# **Contributors**

|  |  |
| --- | --- |
| Name |  |
| Date | Click or tap to enter a date. |
| How the person prefers to be addressed |  |
| People & roles who contributed |  |

**ISP**

# **Discovery Assessment Summary**

## Important To/Important For

|  |  |  |
| --- | --- | --- |
| **Assessment**  **Area:** | **Important To:** What makes the person feel satisfied, content | **Important For:** Health, safety, valued member/social role |
| Communication |  |  |
| Advocacy & Engagement |  |  |
| Safety & Security |  |  |
| Social & Spirituality |  |  |
| Daily Life & Employment |  |  |
| Community Living |  |  |
| Healthy Living |  |  |

## Skills and Abilities: *What is the person good at, what can they do on their own, what do they have to contribute*

|  |  |
| --- | --- |
| Communication |  |
| Advocacy & Engagement |  |
| Safety & Security |  |
| Social & Spirituality |  |
| Daily Life & Employment | Path to Employment: (will auto-populate from assessment in IT system) |
| Community Living |  |
| Healthy Living |  |

## Known and Likely Risks *– include any MUI trends and preventative measures*

**Levels of Supervision and Definitions:**

1. **No Paid Supports:** The person can be alone and does not require any paid/remote support to ensure safety for (time frame).
2. **General:** Staff must be able to hear/contact the person if they called for help, and respond within a few minutes.
3. **Auditory:** Staff must be able to hear the person if they called for help and respond quickly.
4. **Visual:** Staff must be able to see the person and be able to provide support or direction.
5. **Close & Constant:** Staff may never leave the person, and must always be able to respond immediately.
6. **Technology:** Describe technology solutions in conjunction with levels 1-5.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assessment area** | **[What is the risk, what it looks like, where it occurs](#Risk1" \o "GUIDANCE: Consider home, work, community, daily routines, other situations (on cell phone, internet, in the bathroom, etc.). Does someone need to be present when the person is dropped off at home? Someone awake during sleeping hours?) (IT to populate from risk summaries in assessment)** | **[What support must look like, why the person needs this support](#Text570" \o "GUIDANCE: Consider - Staff Check-in: The person needs to be checked on by _____________ (type: visual, conversation, tech monitoring) means every _________ (time frame).)** | **Does this risk require supervision? (if yes, please select level)** | **Who is responsible:** |
| Communication |  |  | Choose an item. |  |
| Advocacy & Engagement |  |  | Choose an item. |  |
| Safety & Security |  |  | Choose an item. |  |
| Social & Spirituality |  |  | Choose an item. |  |
| Daily Life & Employment |  |  | Choose an item. |  |
| Community Living |  |  | Choose an item. |  |
| Healthy Living |  |  | Choose an item. |  |
| Amount of time the person can safely be alone: | |  | | |
| Provider Back-Up Plan: | |  | | |

# **Outcomes/Experiences (copy/paste template for additional outcomes, add/delete lines as needed)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Summary of Progress:** *Share accomplishments and progress as they occur and show how success is to be celebrated* | | | |
|  | | | |
| **Outcome:** *What does the person want to accomplish and why?* | | | |
|  | | | |
| **Details to Know** | | | |
|  | | | |
| **Experiences:** *In order to accomplish the outcome, what experiences does the person need to have?* | | | |
| **What needs to happen** | **How it should happen** | **Who is responsible** | **When/How often** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Outcome/Experiences Review** | | |
| **What will progress look like/How will we know it is happening?** | **Who** | **When to check in** |
|  |  |  |
|  |  |  |
| **Important and Relevant History:** *Only include history that may impact the person’s life, supports, and achievement of outcomes.* | | |
|  | | |

# **Services and Supports**

## Paid Supports (copy/paste template for additional providers, add/delete lines as needed)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Who is responsible** | PROVIDER NAME: | | | | | | | | | | |
| **Assessment area** | **Funding source** | | **Service name** | | **Scope of service/What support looks like** | | | | **How often/ How much?** | | **Begin date/End date** |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| Choose an item. | Choose an item. | |  | |  | | | | Choose an item. | |  |
| **Does this person meet criteria for any add-ons?** *Select all that apply* | | Medical Assistance Rate Modification | | Behavior Support Rate Modification | | Intermediate Care Facility Rate Modification | Complex Care Rate Modification | Developmental Center Rate Modification | | Children’s  Intensive Behavioral Support Rate Modification | |

## Additional Supports: *Family, friends, community resources, technology, etc. (add/delete lines as needed)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment area** | **Who supports** | **What support looks like** | **When/How often:** |
| Choose an item. |  |  |  |
| Choose an item. |  |  |  |
| Choose an item. |  |  |  |

## Professional Referrals: *Medical professionals, therapists, etc. (add lines as needed)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment area** | **New or existing** | **Who supports** | **Reason for referral** |
| Choose an item. |  |  |  |
| Choose an item. |  |  |  |
| Choose an item. |  |  |  |

# Team Members – Participation & Informed Consent/Agreement

|  |
| --- |
| **Person Supported/Family/Guardian** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Were restrictions identified during the planning process?** | Yes  No | **RM - Date of HRC Approval:** | Click or tap to enter a date. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **RM - What help do I need to keep myself safe?** (Describe restrictive strategies and why they are needed). | | | | |
|  | | | | |
| **RM - What is the plan to ensure the restriction is temporary in nature?** | | | | |
|  | | | | |
| **RM - What could happen if I allow this help?** | | | | |
| **Good** | **Bad** | | | |
|  |  | | | |
| **RM - If I don’t allow this help, what other ways help me be safe?** | | | | |
| **Good things about these other options** | **Bad things about these other options** | | | |
|  |  | | | |
|  | | | | |
| I understand that I can change my mind at any time. I just need to let [Insert SSA/QIDP] know. | | Yes | No |  |
| I understand I can contact someone at [Provider Agency Name] if I want to file a complaint.  Contact: | | Yes | No |
| I agree this plan contains supports to meet my health and welfare needs. | | Yes | No |
| Individual rights have been reviewed with me. | | Yes | No |
| I understand the purpose, benefits, and potential risks. I agree and consent to this entire plan. | | Yes | No |
| Technology solutions have been explored by my team and me | | Yes | No | N/A |
| Free Choice of Provider has been explained to me. | | Yes | No | N/A |
| I have been given my due process rights. | | Yes | No | N/A |
| I have been given information on residential options. | | Yes | No | N/A |

## Signatures (add/delete lines as needed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **All Team Members:** By signing below, I agree that this plan reflects actions, services, and supports as requested by the person listed. As a provider, I agree to the services listed in this plan for which I am named a responsible party. I understand that I may revoke my consent at any time verbally or in writing in accordance with DODD Rules. | | | | |
| **Team member** | **Name/Relationship** | **Participated in planning** | **Signature of approval for supports as outlined in this plan** | **Date** |
| Choose an item. |  | Yes  No |  | Click or tap to enter a date. |
| Choose an item. |  | Yes  No |  | Click or tap to enter a date. |
| Choose an item. |  | Yes  No |  | Click or tap to enter a date. |
| Choose an item. |  | Yes  No |  | Click or tap to enter a date. |
| Choose an item. |  | Yes  No |  | Click or tap to enter a date. |

## Dissenting Opinions (add/delete lines as needed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Team member** | **Name/Relationship** | **Areas team members disagree** | **How to address** | **Date** |
| Choose an item. |  |  |  | Click or tap to enter a date. |
| Choose an item. |  |  |  | Click or tap to enter a date. |

# **Contact Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | Preferred Name | | |  | | | | | | Email |  | | |
| Address: |  | | | | | City, State, Zip | | | |  | | | | | | | |
| County |  | | Phone |  | | | | |  | Sex | | Choose an item. | | | | Status | Choose an item. |
| Best way to connect with the person | | | | | | Choose an item. | | | |  | | | | | | | |
| ISP Span Dates | | - | | | | Funding Source(s) | | | | | Choose an item. | | | | | | |
| **Important People** (add/delete lines as needed) | | | | | | | | | | | | | | | | | |
|  | | | Name | | | | Address | | | | | | Email | | | | Phone |
| Choose an item. | | |  | | | |  | | | | | |  | | | |  |
| Choose an item. | | |  | | | |  | | | | | |  | | | |  |
| Choose an item. | | |  | | | |  | | | | | |  | | | |  |
| **Important Clubs, Groups, Organizations** (add lines as needed) | | | | | | | | | | | | | | | | | |
| Choose an item. | | | Name: | | | | Address | | |  | | | | | | Phone |  |
|  | | |  | | | | When/Meeting info | | |  | | | | | | Who helps |  |
| **Important Places** (add lines as needed) | | | | | | | | | | | | | | | | | |
| Choose an item. | | | Name: | | | | Address | | |  | | | | | | Phone |  |
|  | | |  | | | | Schedule | | |  | | | | | | Acuity |  |

\*\*Disclaimer\*\* Please note that some personal confidential information has been removed from this copy of the individual’s OhioISP.

# **Introduction Page**

|  |  |
| --- | --- |
| **It’s All About Me** | |
| **(Person’s Name)**  **(Preferred Name)** | **{Insert Picture here}** |
| ***What people like and admire about me…*** | |
|  | |
| ***A few things important to me…*** | |
|  | |
| ***A few things important for me…*** | |
|  | |
| ***Here’s how you can support me…*** | |
|  | |