

Name:

Record Number:

Cumberland County Mental Health Center CAP-MR/DD Waiting List Assessment

An individual is appropriate for CAP-MR/DD referral ONLY if he/she meets the criteria for ICF-MR Level of Care which requires a Mental Retardation or similar diagnosis resulting in substantial functional limitations in three or more major life areas (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living) and requiring active treatment.

Date: _____

I. BACKGROUND INFORMATION:

Name: _____
Last First Middle Maiden (if applicable)

Address: _____
Street P. O. Box

_____ City State Zip Code County

Telephone #: _____

Date of Birth: _____ Nickname or other preferred name: _____

Sex: ___ Female ___ Male Marital Status: ___ Single ___ Married ___ Divorced Primary Language: ___ English ___ Spanish ___ Sign ___ Other: _____

Referral Source: _____ Phone #: _____
Who referred individual (parent, psychologist, case mgr., teacher, etc.)? Please give name and title.

Guardian/Legally Responsible Person: _____
Last First Middle

Address: _____
(If different from applicant) Street City State Zip Code

Telephone #: (Home) _____ (Work) _____

√	TYPE OF GUARDIANSHIP	DATE OF ADJUDICATION
	Parent of a minor	N/A for Parent of a Minor
	Guardian of the Person	
	Guardian of the Estate	
	Limited Guardianship (please specify)	

If different from guardian/legally responsible person above, complete the following:

Mother _____
Last First Maiden Address (if different from the applicant)

Father _____
Last First Middle Address (if different from the applicant)

Has individual ever received services through the Area Mental Health, Developmental Disabilities and Substance Abuse Program?

___ Yes ___ No If Yes, please give the dates: From: _____ To: _____

Please list specific services previously received if applicable: _____

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II. DISABILITIES/CURRENT SERVICES AND SUPPORTS:

Diagnostic Information (check ALL that apply)

Mild Mental Retardation Attention Deficit/Hyperactivity Disorder Autism

Moderate Mental Retardation Developmental Delay Seizure Disorder

Severe Mental Retardation Cerebral Palsy Traumatic Brain Injury
Date of Injury: _____

Profound Mental Retardation Down Syndrome Mental Illness (specify diagnosis)

Unspecified Mental Retardation Learning Disability _____

Other (please specify) _____

ATTACH MOST RECENT PSYCHOLOGICAL EVALUATION AND ANY AVAILABLE MEDICAL RECORDS THAT DOCUMENT DIAGNOSIS.

Where the person lives:

___ At home with biological family including: ___ mother ___ father ___ sisters/brothers-how many: _____
Other: ___ grandparent ___ Aunt/Uncle ___ Other Relative _____
(Specify)

___ Foster family including: ___ foster mother ___ foster father ___ sisters/brothers-how many: _____

___ Group home. Number of others living in-group home: _____

___ State ICF-MR ___ Community ICF-MR ___ Other: _____
(Specify)

Services and Supports the person receives NOW (include school, work, residential supports, family and friend supports):

___ School Name: _____ Grade (if applicable): _____
Special services received at school: _____

___ Vocational or work placement. Name: _____

___ Specialized therapies: ___ PT ___ ST ___ OT ___ Psychology ___ Nursing ___ Recreation ___ Dietary
___ Other: _____

___ Other supports (*complete below*) CURRENTLY received by individual from programs, family and friends:

√	Person or Provider	Services/Help Received	Contact Person	Phone Number
	CAP-C			
	CAP-DA			
	Medicaid Personal Care			
	State Funded Respite			
	Tri-Care Specialized Services			
	Vocational Rehabilitation			
	TEACCH			
	ADVP or Other Day Program Name of Prog. _____			
	Psychological			
	Family			
	Friends			
	Other:			

III. Tell Us About The Person's Special Needs:

Communication:

Expressive: (Check ONE ONLY)

- 1. ___ Speaks clearly for age. Makes needs known.
- 2. ___ Speaks clearly but has difficulty making needs known.
- 3. ___ Speech is not clear, but can be understood by those who know the person.
- 4. ___ Uses other communication to speak such as gestures or sign language. Makes needs and thoughts known through gestures or signs.
- 5. ___ Uses some signs but does not communicate basic needs and thoughts.
- 6. ___ Uses augmentative communication such as pictures or an electronic system (communication board) to communicate basic needs and thoughts.
- 7. ___ Uses augmentative communication, but has limited expression.
- 8. ___ Does not intentionally express self consistently through speech, signs, pictures, or communication board

Receptive: (Check ONE ONLY)

- 1. ___ Understands most spoken language.
- 2. ___ Understands only some spoken language.
- 3. ___ Understands little spoken language.
- 4. ___ Understands only through gestures, signs, and/or pictures.
- 5. ___ Responds to speech or sounds but does not understand meaning of words.
- 6. ___ Does not respond consistently to speech or sounds.

Behavior: (Check ALL that apply)

Child (ages 0 – 17)

- 1. ___ Tantrums. How often? _____
- 2. ___ Usually follows directions given by adults
- 3. ___ Rarely follows directions given by adults
- 4. ___ Hits others. How often? _____
- 5. ___ Uses objects as weapons. How often? _____
- 6. ___ Unable to control anger. What does he/she do? _____
- 7. ___ Unusual fears. What are they? _____
- 8. ___ Inappropriate sexual behavior? What does he/she do? _____
- 9. ___ Is medication given for behavior or attention deficit disorder? Name of medicine: _____
- 10. ___ Behavior program or behavior guidelines are in place. Does this help? _____
- 11. ___ Wanders or runs away? Explain. _____
- 12. ___ Self-Injurious behavior? Describe and frequency: _____
- 13. ___ Destroys Property? Describe and give frequency: _____

Adult (ages 18 and up)

- 1. ___ Cooperative and usually follows rules, appropriate instructions and directions.
- 2. ___ Only occasionally follows rules and instructions even though he/she understands the rules/instructions.
- 3. ___ Temper outbursts without physical violence. How often? _____
- 4. ___ Temper outbursts with physical violence. How often? _____
- 5. ___ Hitting or assaulting others. How often? _____
- 6. ___ Uses objects as weapons? How often? _____
- 7. ___ Inappropriate sexual behavior. How often? _____ Define behaviors: _____
- 8. ___ Medication is given for behavior or psychiatric disorders. Name of medicine(s): _____
- 9. ___ Behavior program or behavior supports are in place. Is it working? _____
- 10. ___ Wanders or runs away? Explain.: _____
- 11. ___ Self-Injurious behavior? Describe and give frequency: _____
- 12. ___ Destroys Property? Describe and give frequency: _____

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IV. MEDICAL AND RELATED NEEDS:

Medical needs requiring family or caregiver support: (Check ONE ONLY)

1. Medical needs are routine for age (i.e. annual physicals, regular check ups for children.)
2. The individual has frequent illnesses and goes to the doctor often. Types of illnesses: _____
3. The individual has medical conditions which require caretakers to perform special tasks at home to take care of him/her. These tasks are: _____
 The caretaker is able to perform these special tasks without problems.
 The caretaker is having difficulty performing these special tasks because: _____
4. Individual has been hospitalized frequently. Reasons for hospitalization: _____
5. Caretaker receives outside assistance in providing medical care for the individual. Assistance is provided by:
 other family members
 friends
 paid staff
 nurses

LIST CURRENT MEDICATIONS (list additional medications on back if necessary)	
Name of Medication	Symptoms/Reason Taken For

Does the person need help with taking their medicine? Yes No

Seizures	Seizure Type	Frequency
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Height _____ Weight _____

	√ Normal/ No Problems	Problems-Describe
Vision		
Hearing		
Teeth (dental)		
Skin		
Diet (i.e. formula)		

Please list additional medical issues/concerns including needed medical supplies/equipment.
Please list any known allergies:

Specialized Therapies:

Specialized therapies are needed to enhance development or medical status. Therapies **NEEDED (NOT CURRENTLY RECEIVING)**:

PT OT Psychology Dietary Recreation Speech Nursing
 Other: _____

Ambulation (Mobility-ability to move around or walk). Check ONE ONLY.

1. Normal for age
2. Partially Ambulatory (walks with assistance from braces crutches walker or other adaptive equipment).
3. Non Ambulatory-Mobile (moves around with assistance from adaptive equipment such as a wheelchair).
4. Non Ambulatory-Non-Mobile (unable to move from place to place without assistance from others. Requires total assistance from others to use adaptive equipment).

V. SELF HELP AND PERSONAL CARE:**Self-Help/Self-Care****Dressing: (Check ONE ONLY)**

1. Dresses self appropriately for age
2. Dresses/undresses self with verbal reminders (including selecting appropriate clothing for season, occasion, etc).
3. Assistance with dressing/undressing needed (including help with fasteners). More assistance than usual for age.
4. Requires total assistance with dressing and undressing. Depends on others for this support.

Toileting: (Check ONE ONLY)

1. Toilets independently for age.
2. Toilets with occasional reminders and assistance (not expected for age).
3. Requires prompting and/or physical assistance for toileting on a consistent basis (assistance not usual for age).
4. Full assistance for toileting or not toilet trained (expectation that person should be toilet trained at current age).

Eating: (Check ONE ONLY)

1. Eats independently for age
2. Eats independently, but has poor use of utensils, is messy for age.
3. Eats with assistance from others. Not expected for age.
4. Depends on others to be fed. Not expected for age.
5. Tube Feeding is required

Bathing: (Check ONE ONLY)

1. Bathes self independently for age.
2. Needs verbal instructions or reminders and should be independent for age.
3. Needs physical assistance and should be independent for age.
4. Total Assistance required for bathing and should be independent for age.

VI. Accessing the Environment:**1. Access to familiar indoor environments: (Check ONE ONLY)**

With or without adaptive devices, the individual moves around in a familiar environment without assistance (home, classroom, work environment).

The individual requires assistance (verbal or physical) to move around in familiar environment due to physical, behavioral, or cognitive disabilities.

2. Access to familiar outdoor environments: (Check ONE ONLY)

The individual independently for age, accesses familiar locations in his environment (back yard, next door neighbors, walks to store, bus stop, etc.).

The individual requires greater monitoring and assistance than a non-disabled individual of the same age, to access familiar locations in his environment such as the back yard, neighbors, local store, etc due to physical, behavioral or cognitive deficits.

VII. Use of Items in the Environment:**1. Use of items in environment:**

The individual uses/operates familiar items of interest/need appropriately for age, with minimal assistance (telephone, television, eating utensils, toys, brush, comb, etc)

The individual requires assistance from another person to use items of interest/need due to physical, behavioral or general cognitive problems.

2. Ability to self entertain and enjoy items in the environment:

The individual interacts independently for age with common items of interest for age for entertainment (movies, games, toys).

The individual requires assistance to use items for pleasure or entertainment. Items must be selected by others or others must facilitate interaction due to physical, behavioral, or cognitive impairments of the individual.

VIII. Adaptive Equipment and Supported Protective Devices

____ Individual does not need adaptive equipment.
 ____ Individual has or needs equipment. Complete Below:

(Check Has or Needs for ALL that apply)

Has	Needs	Adaptive Equipment	Has	Needs	Adaptive Equipment
		Wheelchair			Supportive Belts
		Walker ____ Crutches ____ Braces ____			Bedrails
		Hearing Aid			Lap Tray
		Glasses			Modified Shoes
		Adaptive Clothing			Mittens ____ Splints ____
		Adaptive Utensils			Helmet
		Other:			Aug. Comm.

<i>What type of future adaptations may be needed?</i>

IX. SOCIAL INTERACTIONS:

Check ONE ONLY:

- ____ The individual initiates/interacts with others in a manner generally appropriate for his/her age.
- ____ Initiates/interacts with others in a manner more typical of a younger child.
- ____ Social interactions skills are limited. Explain: _____
- ____ Does not understand social interactions initiated by others (greetings, etc) or responds inconsistently or inappropriately. Requires assistance to facilitate social interaction (due to physical or cognitive limitations) or re-direction for inappropriate interactions.

Check ONE ONLY:

- ____ Generally demonstrates appropriate (for age) physical contact for situation (handshake, hug, kiss, etc).
- ____ Requires verbal or physical reminders or intervention to ensure appropriate type of physical contact for situation due to physical, behavioral, or cognitive limitations.
- ____ Physical contact is often inappropriate for age (touching, hitting, biting, etc) requiring supervision to prevent such behavior.
- ____ The individual displays inappropriate sexual contact. Explain: _____

X. HEALTH AND SAFETY:

Safety with common objects (understanding danger with objects). Check ONE ONLY:

- ____ Within familiar environment (home, school, group home, work, etc), the individual recognizes danger in the form of items (hot, sharp, non-edible) and responds appropriately for age.
- ____ Within familiar environment (home, school, work, etc), the individual requires greater monitoring than a non-disabled person of the same age with common objects (hot, sharp, non-edible).

Understanding of Dangerous Situations. Check ONE ONLY:

- ____ Within familiar environment (home, school, group home, work, etc), the individual recognizes dangerous situations such as traffic, bodies of water, fire, etc.) and responds appropriately for age.
- ____ When compared to individual of the same age, the person appropriately (for age) requests assistance with danger (calls for help, could state name if lost, etc).
- ____ Individual requires monitoring and supervision in proximity to danger (i.e. traffic, water, etc.). This supervision is more than would be provided for a non-disabled person of the same age.

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Night Supervision Requirements:

1. ____ Adult: Individual can remain alone in a residence at night without supervision.
2. ____ Adult: Individual requires access to supervision during the night.
3. ____ Adult or child: Individual requires frequent intervention during the night due to sleep disorders, behavioral, physical or other medical needs.
4. ____ Adult or child: Individual requires awake supervision during the night to maintain health and safety due to sleep disorders, behavioral, physical or other medical needs.
5. ____ Child: Individual does not require awake supervision and sleeps through the night.

XI. SERVICE NEEDS:

Please check all that apply.

Hourly Support Services			
<input type="checkbox"/>	Home and Community Supports (habilitative training provided in the home & community)	<input type="checkbox"/>	Personal Care (assistance with bathing, dressing, eating, etc.; monitoring; non-habilitative support)
<input type="checkbox"/>	Respite (provides periodic relief for primary caregiver)	<input type="checkbox"/>	Day Supports (habilitative training provided in licensed day facility)
<input type="checkbox"/>	Crisis Services (one additional support person during acute crisis situations)	<input type="checkbox"/>	Individual/Caregiver Training & Education (specialized education and training, as needed, for individual and/or family to enhance overall care)
<input type="checkbox"/>	Specialized Consultative Services (provides expertise, training, and technical assistance from a consultant in a specialty area)	<input type="checkbox"/>	Supported Employment (activities needed to sustain paid work by individuals receiving waiver services including supervision and training)
<input type="checkbox"/>	Other:	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
Daily Support Services			
<input type="checkbox"/>	Residential Supports (habilitative training and/or personal care provided for individuals living in residential placement such as a group home, AFL, etc.)	<input type="checkbox"/>	
<input type="checkbox"/>	Other:	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

How would these services help the person? _____

How would they help his/her family or significant others? _____

XII. Special Circumstances That May Impact Needs and/or Service Delivery:

Name:

Record Number:

XIII. Other Service Considerations and Referrals: (IMPORTANT/PLEASE COMPLETE)

What other referrals have been made or considered?

√	Service	Referral Made (Date)	Disposition (On Wait List, Appt. Made, No Services Available, etc.)
	CAP-C		
	CAP-DA		
	Medicaid Personal Care		
	TEACCH		
	Vocational Rehabilitation		
	Tri-Care Specialized Services		
	ADVP or Other Day Program Name of Prog. _____		
	Psychological		
	Other:		

If no other services have been considered or referrals made, please explain why: _____

XIV. Financial and Insurance Information. Check ALL that apply:

___ SSI _____ Monthly Amount
___ SA _____ Monthly Amount
___ Other- Specify: _____ Monthly Amount: _____
___ Trusts/Reserves/Funds in Consumer's name exceed \$2,000.

Medicare: Are you currently receiving Medicare: Yes No
Medicare #: _____ Effective Date: _____
Consumer's name AS IT APPEARS on the Medicare card: _____
Are you eligible for coverage under the Veteran's Administration? Yes No
Are you disabled and receiving Social Security benefits? Yes No

Medicaid: Are you currently receiving Medicaid? Yes No
Medicaid #: _____
Consumer's name AS IT APPEARS on the Medicaid card: _____
Most recent Medicaid effective dates: From: _____ To: _____
Please indicate color of Medicaid card: Buff Blue

Is the consumer currently covered by private insurance? Yes No
If yes, please list insurance information below:
Insurance Company: _____
Insured Party: _____ Group #: _____
Individual #: _____ Policy #: _____
Claims Address: _____

Telephone #: _____ Effective Date of Insurance: _____

Name:

Record Number:

XIV. Informant:

Name: _____

Relationship: _____

Date: _____

Assistance in completing this application was provided by:

Name: _____

Relationship/Agency: _____

IF NC SNAP CERTIFIED, COMPLETE AND ATTACH COPY OF NC SNAP (1st Page Only)

_____ **Please Do Not Complete Below This Line** _____ **For LME Use ONLY** _____

LME:

NC-SNAP Level: _____

Individual has substantial functional limitations in the following areas of major life activity:

(Check all that apply)

1. ___ Self-care: ability to take care of basic life needs for food, hygiene, and appearance.
2. ___ Understanding and use of language: ability to both understand others and express ideas or information to others either verbally or non-verbally.
3. ___ Learning: ability to acquire new behaviors, perceptions and information and apply experiences to new situations.
4. ___ Mobility: semi or non ambulatory.
5. ___ Self-direction: managing one's social and personal life and ability to make decisions necessary to protect one's self.
6. ___ Capacity for independent living: age appropriate ability to live without extraordinary assistance.

Disposition:

- ___ 1. Refer to other program. Specify: _____
- ___ 2. Put on Waiting List.
- ___ 3. Does not meet ICF-MR Level of Care Criteria.
- ___ 4. Screened needs are appropriate for further inquiry.
- ___ 5. Screened needs are currently met through other resources/services.
- ___ 6. Other. Describe: _____

Signature: _____ Date: _____

LME Representative/Title