NH Bureau of Developmental Services Functional Screen for Waiver Services

APPLICANT'S DEMOGRAPHIC INFORMATION

Applicant Name (first)	Middle Initial	Last	Suffix

Gender ☐ Female ☐ Male	Applicant's Medicaid I.D.	Date of Birth (mm/dd/yyyy)	Area Agency (number and name)

Applicant's Street Address:

City	State	Zip Code

Telephone - Home	Telephone - Work	Telephone - Cell

GUARDIANSHIP

Individual has court appointed guardian ☐ Yes ☐ No If "Yes" provide guardian information

Name (First)	(Middle)	(Last)

Address

City	State	Zip Code

Telephone - Home	Telephone - Work	Telephone - Cell

TARGET GROUP: Indicate one Waiver selection

☐ DD Waiver ☐ ABD Waiver ☐ IHS Waiver

Does the applicant have a disability determination from a qualified medical professional?

☐ Yes ☐ No

RESIDENTIAL SERVICES (must select one)

☐ He-M 521 ☐ Independent Living
☐ He-M 525 ☐ License Facility #
☐ He-M 1001 ☐ NA
☐ EFC Certified #
☐ Staffed Residence Certified #

DAY SERVICES (must select one)

☐ He-M 507 Certification Number:
☐ He-M 521
☐ He-M 525
☐ NA

CLINICAL INFORMATION - to be completed by a person with knowledge of the individual's current clinical status.

DIAGNOSES: Check all those documented in individual's medical record; at least one must be selected.

Developmental Disability:

☐ Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe
☐ Autism Spectrum Disorder
☐ Downs Syndrome
☐ Learning Disability (please specify)_____
☐ Other Qualifying Condition/Syndrome (please specify)
☐ Epilepsy/Seizure Disorder
☐ TBI onset prior to age 21
☐ Cerebral Palsy

Acquired Brain Disorder:

☐ Traumatic Brain Injury onset after age 22, prior to age 60
☐ Cerebral Vascular Accident (CVA, Stroke)
☐ Infectious brain disease (specify) _____
☐ Other Neurological Disorders (Huntingtons, MS, etc.) :
☐ Anoxia
☐ Brain Tumor
☐ Intracranial Surgery

Other Medical Condition(s):

☐ Underlying medical condition which effects level of care, if any (please specify) _____

Mental Illness:

☐ Anxiety Disorder (PTSD, OCD) ☐ Major Depression ☐ Personality Disorder (specify): _____
☐ Bipolar Disorder ☐ Schizophrenia ☐ Other (specify):

Impairments:

Visual	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No
Speech	☐ Yes	☐ No	Joint Motion	☐ Yes	☐ No
Hearing	☐ Yes	☐ No			

Specialty Care: Other:

G-Tube	☐ Yes	☐ No
Vent/Trach	☐ Yes	☐ No
Oxygen	☐ Yes	☐ No

Therapies: OT: ☐ Yes ☐ No PT: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

ADLs (ACTIVITIES OF DAILY LIVING)

Level of Assistance Scale

0 - Person is **completely** independent in his/her ability to safely accomplish task.

1 - Assistance, including supervision, cueing, or hands-on, is necessary for the individual to complete the task safely, but **helper DOES NOT have to be physically present throughout.**

2 - Assistance, including supervision, cueing, and/or hands-on assist, is necessary to safely complete the task with **helper present throughout** or task is not age appropriate.

IADLs (Instrumental Activities of Daily Living)		Select only one box
BATHING	The ability to shower and/or bathe to maintain adequate hygiene, including the ability to: get in and out of the shower and/or tub; turn faucets on and off; regulate water temperature; wash; and dry fully.	☐ 0 ☐ 1 ☐ 2
	Select all adaptive equipment used, if any: ☐ Grab Bar(s) ☐ Shower Chair ☐ Tub Bench ☐ Mechanical Lift	
DRESSING	The ability to dress/undress including selection of weather appropriate clothing, completed with or without assistive devices; this includes fine motor coordination for buttons and zippers on the front of clothing (do not include difficulties with zippers and/or buttons at the back of an article of clothing).	☐ 0 ☐ 1 ☐ 2
EATING	The ability to eat and drink using routine or adaptive utensils, this includes the ability to cut, chew, and swallow food. Note: If individual is fed via tube or intravenous, check "0" if they can accomplish task themselves, or "1" or "2" if assistance is required.	☐ 0 ☐ 1 ☐ 2
MOBILITY IN HOME	The ability to move between locations in the individual's living environment-defined as kitchen, living room, bathroom, and sleeping area (excluding basements, attics, yards, and any equipment used outside the home).	☐ 0 ☐ 1 ☐ 2
	Indicate all adaptive equipment used, if any: ☐ Cane in Home ☐ Quad-Cane in Home ☐ Wheelchair/Scooter in Home ☐ Crutches in Home ☐ Prosthesis ☐ Walker in Home ☐ Person assist/other physical support	
TOILETING	The ability to use the toilet, commode, bedpan, or urinal, including ability to transfer on/off the toilet, cleansing of self, managing an ostomy or catheter, and adjusting clothes.	☐ 0 ☐ 1 ☐ 2
	Indicate all adaptive equipment/strategies used, if any: ☐ Grab Bar(s) ☐ Ostomy ☐ Commode or adaptive equipment ☐ Training Protocol ☐ Urinary Catheter	
	INCONTINENCE: *not including stress incontinence* ☐ Does not have incontinence ☐ Has incontinence daily ☐ Has occasional incontinence ☐ Regular training protocol	
TRANSFERRING	The ability to get in and out of bed and to move between surfaces: bed/chair to wheelchair, walker or standing position (include the ability to use assistive devices for transfer).	☐ 0 ☐ 1 ☐ 2
	Select all adaptive equipment used, if any: ☐ Grab Bar(s) ☐ Shower Chair ☐ Tub Bench ☐ Mechanical Lift	

IADLs (Instrumental Activities of Daily Living)		Select only one box
MEAL PREPARATION	Independent	☐ 0
	Needs assistance weekly (e.g., meal planning, grocery shopping)	☐ 1
	Needs help with every meal	☐ 2

MEDICATION ADMINISTRATION AND MANAGEMENT	Has no medication	☐ 0
	Self-Administering/Independent (with or without assistive devices)	☐ 1
	CANNOT direct the task; is required to have medications administered	☐ 2
MONEY MANAGEMENT	Independent	☐ 0
	Needs monitoring	☐ 1
	Needs help from another person with all transactions	☐ 2
LAUNDRY and/or CHORES	Independent	☐ 0
	Needs help from another person weekly or less often	☐ 1
	Needs help more than once a week	☐ 2
TRANSPORTATION	Individual drives regular vehicle	☐ 0
	Individual is able to take public transportation	☐ 1
	Individual cannot drive due to impairment(s), including no driver's license.	☐ 2

EMPLOYMENT/VOLUNTEER

Section concerns the need for assistance to perform employment specific activities. The need for help with ADLS and IADLs (e.g., transportation, personal care) is captured in other sections, this section concerns only those supports necessary for successful performance of job duties.

A. Current Employment Status (select one):

☐ Working full time (paid work avg 30 or more hours per week)
☐ Working part-time (paid work avg less than 30 hours per week)
☐ Not Working (engages in no paid work)
☐ Retired (age 65+ only)
☐ Volunteer

B. Need for Assistance to Work/Volunteer (select one):

☐ Independent (includes use of assistive devices if needed)
☐ Needs help weekly or less (e.g., if a problem arises)
☐ Needs help daily, but does not need the continuous presence of another
☐ Needs the continuous presence of another person

COMMUNICATION AND COGNITION

Communication (select one) Ability to express oneself, including non-English languages, American Sign Language, or other generally recognized communication strategy with or without assistive technology.

☐ Able to fully communicate without impairment or with minor impairment (e.g., slow speech)
☐ Able to fully communicate with the use of assistive device
☐ Able to communicate basic needs to others and/or comprehend basic language
☐ No effective communication

Memory Loss (select one):

☐ No memory impairments evident
☐ Short-term memory loss (seems unable to recall things a few minutes up to 24 hours later)
☐ Unable to remember things over several days or weeks
☐ Long-term memory loss (seems unable to recall distant past)
☐ Memory impairments are unknown or unable to determine

Cognition for Daily Decision Making (select one)

☐ Independent - Individual makes decisions that are generally consistent with his/her own lifestyle, values and goals (not necessarily in alignment with professionals' values and goals).
☐ Individual makes safe decisions in familiar situations, but needs help with new tasks or challenging situations.
☐ Person needs help from another person most or all of the time to ensure safe decision-making

Executive Dysfunction (check all that apply)

☐ Lack of awareness
☐ Lack of initiation
☐ Diminished organization and planning
☐ Impulsivity and disinhibition
☐ Diminished problem solving

Resistant to Care (select one)

☐ Yes, individual is resistive to care due to a cognitive impairment ☐ No

Supervision (select one, two if court ordered)

☐ No supervision required
☐ Less than 24; indicate # of hours per day: _____
☐ 24 Hour supervision
☐ Court Ordered

BEHAVIOR(S)/MENTAL HEALTH

Wandering (select one) Individual has cognitive impairments and leaves residence/immediate area without informing

- ☐ Does not wander
- ☐ Wanders during the day, but sleeps nights
- ☐ Wanders at night, or wanders day and night

Self-Injurious Behaviors (select one) Behaviors that cause or could cause injury to one's own body, including: physical self-abuse (hitting, biting, head banging, etc.), pica (eating inedible objects), and etc.

- ☐ Demonstrates no self-injurious behavior
- ☐ Some self-injurious behaviors requiring intervention weekly or less frequently
- ☐ Self-injurious behaviors requiring interventions 2-6 times per week OR 1-2 times per day
- ☐ Self-injurious behaviors require intensive one-on-one interventions more than twice each day
- ☐ Indicate behavior(s) exhibited: _____

Offensive or Violent Behavior toward others (select one): Behaviors that causes others significant pain, substantial distress, or law enforcement typically called to intervene.

- ☐ Demonstrates no offensive or violent behaviors
- ☐ Some offensive or violent behaviors require occasional interventions weekly or less
- ☐ Offensive or violent behaviors require interventions 2-6 times per week OR 1-2 times per day
- ☐ Offensive or violent behaviors require intensive one-on-one interventions more than twice each day
- ☐ Indicate behavior(s): _____

Substance Use (check all that apply)

- ☐ No active substance use issues evident at this time
- ☐ Individual or others report substance use issue, evidence suggests possibility of a current issue, or a high likelihood of
- ☐ In the past year, the person has had significant problems due to substance use issues, examples include: *police intervention, detox, inpatient treatment, job loss, and/or major life changes.*

RISK TO COMMUNITY SAFETY (check all that apply):

- ☐ No known history of problematic sexual behavior, arson and/or violence
- ☐ History of problematic sexual behaviors, arson and/or violence WITHOUT legal involvement
- ☐ History of legal involvement related to problematic sexual behaviors, arson and/or violence
- ☐ Individual reports deviant thinking related to thoughts of sexual offending, fire setting, or violence

If initial request for services or no waiver services provided in the past year:

Signature of Dr/RN completing form: _____ Date Signed

Print name and phone# of Dr/RN completing form: _____ _____
Name Phone

If change/services renewal:

Service Coordinator: _____ Date Signed

Name and phone # of person completing form: _____ _____
Name Phone

Bureau of Developmental Services
In-Home Supports Waiver Individual/Parent Factors Form

Area Agency Name: Date:

Child's Full Name:

Child's ID:

Childs Medicaid ID:

Eligibility Criteria:

☐ Eligible for AA Services

☐ Medicaid Eligible

Number of Individual Factors:

Number of Family Factors:

Individual Factors: Check all that apply.

☐ Lack of age appropriate awareness of safety issues so that constant supervision is required.

☐ Destructive or injurious behavior to self or others.

☐ Inconsistent sleeping patterns or sleeping less than six hours per night and requiring supervision when awake.

☐ Condition that impedes the ability of the care-giving parent to provide care.

☐ Inability to participate in local community childcare or activity programs without supports.

Parental Factors: Check all that apply.

☐ Care responsibilities for family members with disabilities or health problems.

☐ Age of either parent being less than 18 years or above 59.

☐ Physical or mental health condition, which impedes the ability of the care-giving parent to provide care.

☐ Founded child neglect or abuse as determined by a district court pursuant to RSA 169-C:21.

☐ Availability of only one parent for care-giving.

NH BUREAU OF DEVELOPMENTAL SERVICES WAIVER REQUEST

Submit completed requests to: Bureau of Developmental Services
105 Pleasant St. – Main Bldg, Concord, NH 03301
Phone#: (603) 271-5034 Fax#: (603) 271-5166 email: bds@dhhs.nh.gov

*Criminal record checks, if applicable, must be current, within one year of waiver request.

*Waivers are to be submitted by the Area Agency **ONLY**

***Only complete packets will be processed

Area Agency: **Please choose from list**

Indicate: ☐ - Initial ☐ - Renewal	If **Renewal** Indicate Waiver Number: Expiration Date:	
Provider Agency (if applicable)	Consumer Name (if applicable)	Staff Name (if applicable)
Waiver for: ☐ - Residence ☐ - Day Service	Provide name and address (*as it appears on the certificate)*:	Residence or Day Service Certificate #: Expiration Date:

Indicate specific standard from which you request a waiver: **He-M**
Quote the specific language you seek to waive:

Provide a full explanation of why a waiver to this standard is sought:

Describe proposed alternative to satisfy regulatory intent:

Individual signature (if applicable): _____

Guardian signature (if applicable): _____ Approval Date: _____

Signature of AA Executive Director / Designee: _____ Date:_____

Requested number of years for waiver to be effective (check one): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Permanent